A study of the views and experiences of nursing staff in relation to violence in mental health care settings

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ABSTRACT

This study is an exploration of the views and experiences of nursing staff in relation to violence in mental health care settings. The fieldwork was undertaken at a time when little research had focused on nurses' perceptions of violence in their workplace. Following consideration of debates about epistemology and research methods, a case study design was adopted. The fieldwork took place in the mental health services of one health district. A total of 53 members of the nursing staff took part in the study. They were drawn from six settings: acute intensive care, medium-stay and long-stay continuing care, a rehabilitation hostel, a day hospital and community settings.

Data were obtained through in-depth interviews. The interview guide was developed from a conceptual framework of dimensions of violence and their interrelationships. This framework, in turn, had been developed from a reading of the policy and research literature and comprised the following dimensions of violence: incidence and manifestation; features of the environment; explanation and prevention; management; post-incident events; sources of education and guidance; feelings about violence; views about patients' and nurses' rights and the legal position of the nurse; and inter- and intra-professional relationships. Nurses' views and experiences in relation to each of these dimensions are presented for each of the six settings.

Seven substantive categories emerged from data analysis, and provided an integrating framework for the six settings as a whole. These categories were: appropriate placement; knowing what to do; willingness to discuss; feeling valued; being supported; judging responses; and 'no win' situations. A linking category, 'implementing strategies', was developed. This focused on nurses' perceptions of whether they were able to implement strategies to prevent and manage violence or whether they perceived the power to do so as lying elsewhere. Strengths, limitations and implications of the study are discussed.

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CHAPTER 1: BACKGROUND AND PURPOSE OF STUDY

Violence is regarded as a problem in a wide range of healthcare settings and has a particularly long-standing history in the mental health services. This thesis is an exploration of the views and experiences of nursing staff, working in the mental health services of one health district, in relation to violence in patient care settings. The work for the thesis developed alongside a project based at the Nursing Research Unit, King's College London, which was funded by the then Department of Health and Social Security (DHSS). This chapter describes the commissioning of the project and the development of the thesis (Section 1.1), outlines the subsequent history of both (Section 1.2), provides an overview of the thesis (Section 1.3) and discusses the terminology adopted (Section 1.4). The last section (1.5) outlines theoretical perspectives on aggression and violence.

1.1 DEVELOPMENT OF PROJECT AND THESIS

1.1.1 Concerns about violence in psychiatric services

Increasing concern in the 1980s among members of the nursing section of the DHSS Mental Health Division about violence in psychiatric services led to a request to the Nursing Research Unit of King's College, London University to undertake research on this subject. The Unit is funded by the Department of Health (then the DHSS) with the primary aim of providing research findings that can be used to inform the development of policies pertaining to the nursing workforce. Concerns of DHSS personnel concentrated on perceptions that training leading to qualification, and educational opportunities thereafter, did not always provide nurses with adequate skills and knowledge in relation to preventing and managing violence.

These concerns had been expressed in guidelines on violence in healthcare settings produced in the 1970s by a range of organisations (Royal College of Psychiatrists and Royal College of Nursing 1972, Department of Health and Social Security 1976, Confederation of Health Service Employees 1977). Moreover, the view had been expressed that nurses had become less confident about this aspect of patient care (Packham 1978, Altschul 1981). One reason offered for this trend was increasing fear

of allegations of assault when restraining patients (Packham 1978), particularly since this issue had featured in enquiries into practices at psychiatric hospitals (Martin 1984). Another suggestion was that knowledge and skills in preventing and managing violence had never been adequately developed and that this had become increasingly apparent with the move away from management of violence by physical restraint and/or chemical sedation (Altschul 1981). This lack of knowledge and skill was regarded by DHSS personnel as contributing to difficulties in placing patients with a history of violence but regarded as no longer needing the level of security provided in a secure unit or special hospital.

My preliminary literature review revealed that the role of the nurse in relation to violence in psychiatric services was the subject of a number of publications in the United Kingdom (UK). Views on circumstances most likely to lead to the manifestation of violence, signs that may indicate its imminence and how incidents should be managed had been discussed by several authors, most of whom were, or had been, practising nurses (Frost 1972, James 1972, Harrington 1972, Moffit 1974, Holbrook *et al.* 1977, Packham 1978, Leiba 1980, Altschul 1981, Burrows 1984). The possible relationship of various factors to the incidence of violence had been discussed, including the ward environment, the ward regime, staffing levels and admission policies in relation to available nursing resources (Harrington 1972, Packham 1978, Martin 1984). Many of these authors stressed the need for nursing education at both pre-qualification and post-basic levels to focus on violence to a greater extent than hitherto. There was very little research, however, on nurse education in relation to violence or on the views and experiences of qualified staff about this aspect of patient care (Section 3.9). The focus of most research had been the association of patient and, to a lesser extent, staff characteristics with the incidence of violence (for example Fottrell *et al.* 1978, Aiken 1984).

1.1.2 Commissioning of DHSS funded project

On the basis of the preliminary literature review and discussions with DHSS personnel, a three-year project (1985-1987) was proposed with the following terms of reference:

> *'A study of some aspects of the role and education of the nurse in relation to the prevention and management of violence'*

The project had five parts:

1. Reviewing guidelines on violence available within each of the district health authorities
2. Surveying provision in England and Wales of in-service education on violence
3. Surveying views and experiences of all those who had completed the English National Board Course 955 *Care of the violent or potentially violent individual*
4. Investigating ways in which student nurses taking the three-year course leading to qualification as a registered mental nurse (RMN) and pupil nurses taking the two-year course leading to qualification as a state enrolled nurse (SEN (M)) learnt about violence in each of the modules that comprised their respective courses
5. Exploring views and experiences of qualified nursing staff in relation to violence.

In discussion with DHSS personnel, it was acknowledged that while psychiatric services were the focus of the project, the provision of guidelines (Part 1) and course provision (Parts 2 and 3) would not necessarily have been targeted exclusively at these staff. It was agreed that Parts 4 and 5 of the project would focus on ordinary psychiatric services rather than those provided in secure units and special hospitals, since it was concern about the knowledge and skills of staff in the former that were of concern at the time. The project proposal was accepted by the DHSS and work commenced in early 1985. A research assistant, who was a psychiatric nurse, was appointed from May 1985 until the end of 1987.

1.1.3 Decision to undertake postgraduate research

Several factors led to my decision to undertake postgraduate research based on Part 5 of the project, the views and experiences of qualified nursing staff. It became apparent that it was not feasible to complete all five parts of the project within the agreed timescale. Concurrently, I had decided to undertake postgraduate study and gained agreement that the fifth part of the project be the subject of this work. Such a study was likely to be facilitated by access to fieldwork sites having already been negotiated for Part 4 of the project, the investigation of learner nurses' courses.

The aim of the postgraduate study was to explore the views and experiences of nursing staff in relation to violence in patient care settings. The rationale for the study was to investigate a subject on which little research had focused, but on which research was

required to inform policy development. I proposed to include all the main psychiatric services in the study. Although concerns of DHSS personnel focused primarily on acute services, the preliminary literature review indicated that violent incidents also occurred in other services (Section 3.2.1).

1.1.4 Premises underlying the project and postgraduate study

From preliminary reading and discussions, I recognised that violence within healthcare settings was an emotive subject that staff might be unwilling to discuss. I thought it important, therefore, to be clear about the premises from which I was starting, in terms of the approach taken to the research and the way it was presented to all those asked to participate. The raison d'être for the project and the postgraduate study was that violence in patient care settings in the sense of a physical attack on another person is undesirable and that ways to reduce violence should be sought.

1.2 HISTORIES OF PROJECT AND POSTGRADUATE STUDY

The original timescale for the DHSS project was three years (1985–1987). The plan for the postgraduate study was for fieldwork to be undertaken during the latter part of the period allocated for fieldwork and analysis for the learner nurse study (project Part 4), and then to be written up subsequently. Both the project and the postgraduate study proved somewhat protracted.

Data collection for the guidelines review and the two surveys took place during 1985 and early 1986. Data collection for the study of learner nurses took place in 1986 and 1987. Data collection for my study of staff views and experiences was undertaken primarily during late 1986 and 1987 with preliminary data analysis undertaken concurrently. In late 1987 I experienced the start of a five-year period of ill health, combined subsequently with serious ill health of two members of my immediate family. These events resulted in delays in completion of data analysis and production of reports for the DHSS. By 1988 I had completed a report on the surveys of post-basic education (Robinson and Barnes 1988) and by 1990 a report on the investigation of learner nurses' courses (Robinson 1990).

The resulting backlog of my other DHSS funded work meant that between 1988 and 1992 I had much less time to work on my own study than had been anticipated. From the early 1990s onwards, my role in leading a large Department of Health (DH) funded programme of research on nurses' careers and working lives, combined with all staff, including myself, having renewal of our short-term contracts dependent on successful four yearly reviews of our work, resulted in work on my postgraduate study being somewhat intermittent. Despite being seemingly unable to find sufficient time to bring this thesis to completion I was determined to do so eventually, particularly since the subject continued to be of concern. Moreover, in addition to working on the thesis, my own interest in the subject continued. The impact on job satisfaction of perceived support in managing violent incidents was included in my DH funded studies of nurses' careers. I was a member of an advisory group for a study of how people account for violent and aggressive incidents on an in-patient mental health unit (Benson *et al.* 2003). A short period of part-time study leave finally facilitated completion of the thesis.

1.3 THESIS OVERVIEW

The structure of the rest of the thesis is as follows.

1.3.1 The literature review (Chapters 2 and 3)

Chapter 2 reviews policy developments on violence in psychiatric settings that had particular relevance to nursing staff and Chapter 3 reviews research concerned with, or relevant to, nurses' experiences and views of violence. Both these chapters are in two parts, each first part reviewing developments in the period prior to the start of the study, and each second part reviewing subsequent developments. Sources for these chapters were identified through hand and electronic searches.

1.3.2 Research design and methods (Chapters 4 and 5)

Chapter 4 describes the choice of design and Chapter 5 the methods of data collection and analysis adopted. As the commissioned project of learner nurses and my study of staff were undertaken in the same site, the process of negotiating access related to both. In these two chapters, therefore, details of the learner nurse project are included inasmuch as these were relevant to the design and methods of the study of staff views

and experiences. In these chapters, the former is referred to as the project. the latter as my study and on occasions when they are referred to jointly. as the research.

The study adopted a qualitative design for data collection and analysis. At the outset. there was some pre-structuring with the design of a conceptual framework. research questions and a depth interview guide, but not precluding revision and expansion as the study progressed. The approach to the study was influenced to some extent by the work of Glaser and Strauss (1967) in that it aimed to develop substantive categories from the data, but it did not reach the level of theoretical development that they describe as grounded theory.

1.3.3 Findings (Chapters 6 to 10)

Findings for each of the services included are presented as follows: acute services (Chapter 6); continuing care services (Chapter 7); rehabilitation services (Chapter 8); and community services (Chapter 9). Chapter 10 presents the substantive categories developed for the services as a whole.

1.3.4 Discussion and conclusion (Chapter 11)

Chapter 11 discusses the limitations and strengths of the study and considers the contribution that it makes to knowledge. The final sections focus on implications of the findings for policy and for further research in the context of today's mental health services.

1.4 TERMINOLOGY

This section describes decisions made about the use of terminology throughout the text.

1.4.1 Aggression and violence

I did not provide a definition of aggression and violence to those taking part in my study. since I was interested in how such definitions might vary between respondents. Moreover. the literature indicated that various definitions existed, many of which were somewhat lengthy and I thought it would be more confusing to use one of these rather than the single words in common usage.

The phrase 'the violent patient' is often used in the literature. As several authors had observed, this suggests that violence is a problem located within the patient and sets an agenda for action that may fail to recognise the relevance of the institutional environment, staff attitudes and behaviour, and policies of other professional groups (Coffey 1976, Hodgkinson 1980, Drinkwater 1982). Although aware of this dilemma my approach has been, as far as possible, to use authors' phraseologies when referring to research and policy documents and interviewees' phraseologies when reporting findings.

1.4.2 Nurses and services

There have been several changes in terminology for the titles of nurses and the services in which they work. The original titles of attendants for the former and asylums for the latter gave way to psychiatric nurses and psychiatric hospital and services. Usage then changed to mental *illness* nurses and services and more recently to mental *health* nurses and services. In this account I have adopted the terminology in most common usage during the period under discussion.

1.4.3 Patients and clients

Usage has varied over time as to whether users of mental health services should be referred to as patients or clients. Patients used to be more common but increasingly usage has favoured clients. At the time of the study, users of hospital services tended to be called patients whereas users of community services were more commonly referred to as clients. Rather than move between the two usages for different settings and different periods of time, I have opted for patient throughout.

1.4.4 Education: courses and personnel

Several changes in terminology have occurred in relation to courses and education personnel. When the study was undertaken, the word training rather than education was used to describe nursing courses. Enrolled nurse training was still available and the pupil nurses taking this course and student nurses taking the registered nurse course were referred to collectively as learners. Courses were based in schools of nursing and staff referred to as tutorial staff, a phrase that changed to lecturing staff with the move of nurse education into higher education. Educational opportunities after qualification were usually described as post-basic training or education rather than today's usage of

continuing education or continuing professional development. Throughout the text. the terminology adopted is that in use during the period being discussed.

1.5 AGGRESSION AND VIOLENCE: THEORETICAL PERSPECTIVES

1.5.1 Definitions

Definitions of aggression and violence are diverse. These include those provided by dictionaries and likely to be in common usage. The 1973 shorter Oxford English Dictionary, for example, defines aggression as 'an unprovoked attack; the first attack in a quarrel; an assault' and violence as 'the exercise of physical force so as to inflict injury on or damage to persons or property' (Oxford English Dictionary 1973). Academic disciplines have provided a variety of definitions of both, often as a means of operationalising research studies. Policy documents and research concerned with the incidence, prevention and management of violence often provide a definition of what constitutes a violent incident. As Drinkwater (1982), for example, has argued, lack of consistency in such definitions has created difficulties in comparing findings across studies.

1.5.2 Theories of aggression and violence

Aggression and violence have been studied from many different academic perspectives; these are briefly outlined. Most work in the biological sciences on aggression and violence is based on the view that physiological processes or genetic endowment are their prime determinants. Researchers in the fields of neurology, biochemistry and genetics have sought to identify the particular biological substrates that lead to what they define as abnormal levels of aggressive or violent behaviour (Owens and Ashcroft 1985, Siann 1985). A perspective that locates the origin of aggressive behaviour within individual physiology leads to the implication that behaviour can be changed through the use of drugs, surgery or genetic manipulation (Owens and Ashcroft 1985, Turnbull 1999). As Siann (1985) observes, one of the main criticisms of biological approaches is that they regard biological organisms as essentially reducible to physical systems amenable to modification by physical intervention and little weight, if any, is accorded to the subjective experience of individuals or the social circumstances in which they live.

Psychological explanations are usually considered in terms of instinct theories, aversive stimulation or drive theories, and social learning theories. Instinct theorists consider people to be innately aggressive beings who need to find channels for the expression of such instincts and embrace Freud's theory that humans are governed by instincts located in the subconscious mind and Lorenz's theory, based on the study of animal behaviour, that aggression is adaptive for the survival of individuals and species (Owens and Ashcroft 1985, Siann 1985, Turnbull 1999).

Aversive stimulation theories focus on the conditions under which aggression is exhibited. Early work in this field was that of Dollard who posited that every incident of aggression was the result of a goal being frustrated. Other researchers, such as Buss, made a distinction between reactive or angry aggression, for example hitting someone after being provoked, and operant or instrumental aggression, for example hitting someone during a robbery (Owens and Ashcroft 1985, Turnbull 1999). Berkowitz (1983) maintained that the relationship between frustration and aggression is only an example of a much wider phenomenon, namely that humans are biologically programmed to become aggressive when encountering aversive stimuli.

A third form of psychological explanation postulates that aggression and violence are behaviours like all others and are learned (Breakwell 1989). Two approaches have been influential. The first, instrumental learning, is based on the premise that behaviour can be changed by altering the antecedents or consequences for behaviour, and became particularly influential through Skinner's work on reinforcing behaviour regarded as acceptable and punishing that which was not. The second approach, observational learning, was developed mainly through the work of Bandura (1983) who argued that people learn though observing the behaviour of others either directly or through media images. Another psychological approach to the role played by internal processes in learning that has been influential in understanding human aggression is that of cognitive theory; this maintains that behaviour is not governed by events but by the way in which we interpret them (Turnbull 1999). In relation to aggression and violence, Novaco suggested that it is the ways in which events are interpreted that arouse anger or irritation (Novaco and Welsh 1989).

In her review of perspectives on aggression and violence. Siann (1985) groups together several approaches that consider aggression and violence within a social perspective. These approaches place the 'emphasis not on individual predisposition (whether innately, physiologically or environmentally determined) but on social processes' (Siann 1985, p.174). This body of work has been classified in various ways. Siann (1985) proposed a distinction between perspectives concerned with predictors of violence and perspectives concerned with the meaning of violence. Examples of the former include a longitudinal investigation of aggressive behaviour of schoolboys (West and Farrington 1977).

The second perspective, often described as phenomenological, attempts to understand the meanings of aggression and violence to people labelled as such (Siann 1985). This perspective encompasses a wide range of theories in which 'violence is presumed to share with other forms of social behaviour the properties of rationality, motive and meaning' (Downes 1982, p. 27). Well known studies include: Toch (1972) on violence from the viewpoints of men who had committed violent acts and the police officers who interacted with them; Marsh (1982) on soccer hooliganism from the perspective of participants; Matza (1964) on the values of young people labelled as delinquent; and Box (1983) on corporate crime. The focus in social accounts of aggression and violence thus ranges from informal groupings such as crowds and gangs through to complex and hierarchical corporations (Breakwell 1989).

Some of the above theories have influenced explanations for, and management of, aggression and violence in the context of mental illness. A very substantial body of literature exists on this subject, but lies beyond the remit of this thesis. The account now turns to policy developments concerning the role and education of nurses in relation to violence in psychiatric settings.

CHAPTER 2: NURSING AND VIOLENCE IN PSYCHIATRIC SETTINGS: POLICY DEVELOPMENTS

This chapter focuses on key policy issues and developments concerning violence in psychiatric settings that have particular relevance to nursing staff. These include: ways in which the nature or lack of service provision has been regarded as contributing to violence; difficulties in placing certain groups of patients; the production of guidelines; and changes in the role and education of nurses. Sections 2.1 to 2.6 focus on the period prior to the study and thus provide the policy context within which the study was initiated and designed while Sections 2.7 to 2.10 discuss subsequent developments. The last section (2.11) draws together common themes across the two periods.

2.1 EARLY DEVELOPMENTS

Violence in psychiatric settings emerged as a major concern in the late 1960s in the course of a series of enquiries into allegations of misconduct in mental illness and mental handicap hospitals (Section 2.2). This section focuses on developments in previous periods that set the scene for these events.

Several accounts provide a picture of life for patients and staff in the large psychiatric hospitals that were the main providers of care until the late 1950s (for example, Simpson 1980, Everest 1982, Dingwall *et al.* 1988, Nolan 1993, Goddard 1996). The role of staff included supervising patients in aspects of daily life and when working in various parts of the hospital buildings and grounds. They were also involved in treatment programmes; these differed from one period to another. Early influences on the training of staff emanated from the medical profession through a national training scheme run by the Royal Medico-Psychological Association (RMPA). From the early 1920s, general nursing also began to exert an influence (Dingwall *et al.* 1988, Nolan 1993); a trend regarded as inhibiting adequate development of mental nursing skills when the interpersonal aspects of nurses' roles became more important (Everest 1982).

Nurses interviewed for a history of mental health nursing (Nolan 1993) provided some insights into violence in psychiatric hospitals in the 1920s to 1950s. Their accounts

revealed: the frustration for staff and patients alike of being cooped up in overcrowded wards; variation in staff response to violence; how the incidence of violence on wards varied by the approach of the nurse in charge; and a contrast between hospitals in which patients regarded as likely to attack were seldom approached and others that were characterised by friendly relationships between patients and staff (Nolan 1993). The way in which violence was managed varied according to the treatment ethos of the time. Approaches included mechanical restraints, padded cells, seclusion, surgery, physical restraint and medication (Holbrook *et al.* 1977, Drinkwater 1982, Nolan 1993). Approaches to managing violence varied according to medical superintendents' individual views (Goddard 1996). Looking back at what had primarily been a custodial regime in these hospitals, Coffey observed that while it was subsequently recognised that the nature of the regime itself may have been a major factor in the manifestation of violence, at the time nurses were 'placed beyond the need to examine factors related to violence and especially their own part in its generation' (Coffey 1976, p.343).

Reduced levels of violence were reported as one of the outcomes that resulted from changes in the 1950s in services for the mentally ill. Often characterised as a watershed in the history of these services (Jones 1993), developments of the period included the advent of psychotropic medication, more active programmes of treatment and rehabilitation, policies of unlocking wards, and a growing view that the mental hospital should be part of a comprehensive system of mental health provision rather than its centre. Early reports on the effects of these developments suggest that there were improvements in nurse-patient relationships and reduced levels of violence in the wards that opened their doors (Folkard 1960). In an early study, Folkard (1960) found an overall reduction in the number of incidents during a ten-week period when the door of the study ward was unlocked compared with the previous ten weeks when it was locked.

Increasingly the role of the nurse was defined as one concerned with interpersonal relationships, and nurses were regarded as key therapeutic figures in the changing approaches to the care of mentally ill people (WHO 1963, Ministry of Health 1968). Although a new syllabus was introduced in 1964 with reduced emphasis on general nursing and increased emphasis on psychiatry, psychology and sociology, the 1968 report argued that the influence of general nursing on the syllabus meant that psychiatric nursing had failed adequately to develop a therapeutic role (Ministry of Health 1968).

This conclusion was also reached by several research studies of the nurse-patient relationship undertaken in the 1970s (e.g. Towell 1975, Cormack 1976).

Closer links between mental hospitals and the surrounding community were to some extent implemented in the 1950s but it was government policies in the 1960s that made explicit the transition to community care. Proposals were made to close the large mental hospitals and for care to be provided in psychiatric units of District General Hospitals and through community services such as day hospitals, out-patient clinics and community psychiatric nursing services (Jones 1993). Nolan (1993) has argued that the nursing profession were little consulted about the rationale for, and process of, moving the emphasis of care to the community. Although the policy was slow to be implemented and there were concerns about the adequacy of community facilities, the ideal remained of transition to community care (Department of Health and Social Security 1975). The relative influences of the various imperatives which lay behind this policy have been much debated (Butler 1993, Jones 1993, Prior 1993) but are usually identified as: the economic case that community care would be cheaper to provide than institutional care; the impact of ideological critiques of institutional life; the role of new drugs in controlling symptoms to the point at which rehabilitation and discharge were possible; and the growing view from within some sectors of the mental health professions themselves that large hospitals were an inappropriate milieu for people who were mentally ill.

While an increasing proportion of nurses were involved in community initiatives, it has been argued that for the majority of nurses the policy had two potentially negative impacts. First, those working in hospitals were effectively being told that there was no real future for their specialty and second, there was no incentive to invest resources in institutions that were ultimately scheduled for closure (Martin 1984, Dingwall *et al.* 1988). The low recruitment, high wastage and staff shortages characteristic of the psychiatric nursing workforce during the 1950s and 1960s have been attributed in part to these developments (Nolan 1993). The lack of investment in services and the low morale of staff were identified as contributory factors to the circumstances investigated in the enquiries in some hospitals into allegations of misconduct in which violence often featured (Section 2.2.1).

2.2 ENQUIRIES AND GUIDELINES

Between 1967 and 1980, the subject of violence in psychiatric settings became an issue of widespread professional and public concern in the wake of a series of enquiries into mental illness and mental handicap hospitals and one Special Hospital (Drinkwater 1982). During the 1970s, five national organisations responded to these concerns by producing guidelines for staff on the subject (the brief summary of guidelines below was informed by a review undertaken by my research assistant for the DHSS funded project).

2.2.1 Enquiries into violence in psychiatric hospitals

The enquiries investigated allegations that nurses had physically assaulted patients; the issue for staff, however, was the degree of force they could legitimately use in the course of restraining patients before it became interpreted as ill-treatment (Martin 1984). Reviewing the early enquiries, Coffey (1976) observed that the investigations revealed that poor environments, overcrowding, understaffing, poor leadership and weak management undermined the morale of staff and patients and weakened inhibitions against violence.

From a review of enquiries over a longer period, Martin (1984) showed how violence was a recurring theme in the findings of the reports and he drew similar conclusions to those of Coffey (1976). Overcrowding in hospital wards was regarded as leading to violence and there was a lack of discussion about the placement and management of violent patients. Patient violence placed a serious strain upon nursing staff who were largely unsupported by nursing managers and medical staff whose overall involvement in ward life was low. Many nurses frequently had to cope with violence in understaffed and ill-equipped institutions and there was a serious lack of training and absence of guidance on the subject.

2.2.2 Guidelines on violence

i) Organisational responses

The first organisation to respond was the National Association for Mental Health (NAMH) who produced guidelines which emphasised that although violent incidents involving mentally ill or mentally handicapped patients were rare, it was essential for all

staff to be aware of factors that might precipitate violent actions and be familiar with actions necessary for their control (National Association for Mental Health 1971). The following year guidelines were produced by a Liaison Committee of the psychiatric section of the Royal College of Nursing (RCN) and the Royal College of Psychiatrists (RCP) following a request from the Department of Health and Social Security (RCP/RCN 1972). In 1976, the Department of Health and Social Security produced its own guidance that included the RCP/RCN guidelines amended in light of consultation with health service unions and other interested parties (DHSS 1976).

In 1975 the Confederation of Health Service Employees (COHSE), alarmed at what they perceived as a steadily rising number of violent assaults by patients on psychiatric nursing staff, had set up a multidisciplinary Working Party to examine the problem (COHSE 1977). Attention was also drawn to the vulnerability to attack of community psychiatric nurses, particularly when transporting patients to hospital, since they were working without institutional support mechanisms. As the union then representing most psychiatric nurses, COHSE maintained that they had not been adequately consulted in the preparation of either the DHSS 1976 circular or its appendix and that much of the advice was so general as to be of little use; consequently the Working Party was asked to produce its own guidelines (COHSE 1977).

ii) Recommendations in the guidelines

Considered as a whole, these documents contained a wide range of recommendations; some were aimed at nursing staff in contact with patients, others at those with responsibility for aspects of the service. Recommendations were made that admission of patients should match resources available and that nurses' views should be taken into account in this respect. The COHSE (1977) guidelines added that patients diagnosed as psychopathic should not normally be admitted to ordinary psychiatric hospitals. Guidance was included on: providing a range of therapies and activities to prevent boredom; developing appropriate attitudes to patients; and being sensitive to changes in patients' moods or behaviour. All documents discussed methods of managing incidents; the RCP/RCN (1972) and COHSE (1977) guidelines included details of techniques to be employed. The importance of medical and nursing staff sharing responsibility for preventing and managing violence was emphasised (RCP/RCN 1972, COHSE 1977).

All four guidelines noted the importance of training for staff in the prevention and management of violence and COHSE (1977) expressed concern about its absence.

Recommendations that incident reports be used for discussion and analysis of events were included in all four guidelines. Both the NAMH (1972) and COHSE (1977) guidelines stressed that the focus of discussion should be on learning through evaluation of events rather than apportioning individual blame. COHSE recommended that at post-incident meetings, staff conduct should be judged as to its reasonableness and that senior management should then abide by these conclusions as the basis for support or criticism of those involved (COHSE 1977). In particular, COHSE (1977) emphasised the importance of records in safeguarding staff interests should an enquiry subsequently take place.

The NAMH (1971) and the DHSS (1976) guidelines stated that staff had the right to expect support of their hospital authority where action had been taken in good faith. In differing degrees of detail all the guidelines addressed the question of the legal position of staff involved in incidents. The COHSE (1977) guidelines addressed the nurses' legal position in greater depth than had the others, reflecting practitioners' concerns about ambiguities in the 1959 Mental Health Act over the legal position of staff involved in restraint and concerns that the Act provided little protection for staff having to deal with the violent or potentially violent patient.

iii) Response to guidelines

A range of views was expressed about the guidelines. Coffey (1976) described the guidelines in the DHSS 1976 circular as the embodiment of several key 'practical, ethical and humanitarian principles and as the foundation for the future development of attitudes and practices in the light of new knowledge' (Coffey 1976, p.342). In a critique of the RCP/RCN guidance on management of violent incidents, Drinkwater (1982, p.120) voiced the opinion that these were:

> *'difficult for nurses to follow, as most have no training in how to restrain physically, and therefore lack experience by which to judge the minimum force required. Nor do they know which methods of applying force reduce aggression rather than provoke it. Furthermore, their legal position is not spelt out at all.'*

COHSE (1977) had been very critical of the guidance provided in the DHSS circular. in particular the advice that staff should search patients suspected of carrying a dangerous weapon since, apart from the possible danger to the nurse involved, they had no express legal permission to search even a detained patient. Criticism was also made of the recommendation that decisions on the minimum degree of force necessary to control violence should be left to the discretion of individual nurses. COHSE (1977) maintained this would expose nurses to criticism particularly as, in their view, they traditionally suffered from lack of support from medical staff and senior management over the management of violence and consequently lacked confidence in dealing with incidents. The RCN officer for psychiatric nursing at the time said that the Royal Colleges had not provided more precise guidance since it was virtually impossible to be specific on such a vague subject and, whilst there could be agreement on general principles, much had to be left to the professional judgement of the nurse concerned (Nursing Times 1976).

In considering the content of the guidelines, Hodgkinson (1980) commented that they focused on observation of patients and emphasised violent impulses as patient originated rather than the result of interaction with others. In similar vein, Drinkwater (1982) criticised the DHSS 1976 circular as regarding violence as a manifestation of individual mental disorder and, although the document did acknowledge that environmental factors could foster its expression, she observed that this point was not pursued.

2.3 NURSING EDUCATION AND SKILLS

Partly in response to findings of the early enquiries, the GNC concluded that Registered Mental Nurse (RMN) training was too theoretical and changes should be introduced that would make learning in the clinical setting a priority (Nolan 1993). A new syllabus to this end was introduced in 1974 which also included periods of community experience (White 1990). The syllabus included the following references to violence: communication with the aggressive patient: problems of nursing care and management of suicidal, destructive and violent patients: and the application of behaviour modification techniques in the management of aggression (General Nursing Council 1974).

During the late 1970s the view emerged that nurses had become less competent and confident in managing violent behaviour (Lancet 1976, Packham 1978. Altschul 1981). While a Lancet editorial (1976) suggested that disappearance of locked wards had meant a loss of expertise, Altschul (1981) suggested that knowledge and skills in preventing and managing violence had never been adequately developed and that this was now becoming increasingly apparent. Reasons suggested for loss of confidence included increasing fear of personal injury and anxiety about allegations of assault after physically restraining a patient. Views were also voiced that nurses were becoming increasingly reluctant to put themselves at risk when dealing with difficult patients (Holbrook *et al.* 1977, COHSE 1977) and that nurses working in open psychiatric wards and units were becoming less tolerant of disturbed behaviour than hitherto (Bluglass 1978).

In 1982 a revised syllabus was produced. Designed around a nursing process model of care it aimed to produce nurses who could work in hospital and in community settings. This syllabus stated that students would obtain a knowledge and skill base in relation to preventing, handling and containing violence (General Nursing Council for England and Wales 1982). National implementation of the 1982 syllabus began during 1987 (Standing Nursing and Midwifery Advisory Committee (SNMAC) 1988). Research into learners during the 1985-6 period (Robinson 1990, 1999) showed that most felt that they had been inadequately trained in relation to the management of violence (Section 3.9.1).

Post-basic education on violence included in-service courses provided for staff by their employing authority for which nationally recognised certificates were not awarded and courses provided by the then Joint Board of Clinical Nursing Studies (JBCNS) for which nationally recognised certificates were available. A survey of in-service courses available and planned in 1984 to 1986 showed that many districts had made little provision in this respect (Robinson and Barnes 1988, 1989).

In the late 1970s, there was only one post-basic course concerned specifically with violence. This was JBCNS Course 955, *Care of the violent or potentially violent individual*, which had been introduced in 1978 in response to concerns that post-basic

education on this subject was lacking. The aim of the course was to increase staff knowledge and understanding of factors leading to violent behaviour and means to prevent or reduce its occurrence. It was available to general and psychiatric nurses (registered and enrolled), midwives and health visitors. A study of the course (Section 3.9.2) focused on both its content and participants' views of its usefulness (Robinson and Barnes 1988, 1989). Some sessions on violence were also included in JBCNS Course 960 concerned with principles of nursing in secure environments.

2.4 SERVICE PROVISION AND PLACEMENT OF PATIENTS

During the 1970s there was much debate about appropriate placement of patients in relation to the level of security that they needed, and about the availability of staff expertise in the management of violence.

2.4.1 Locked wards

In 1976, a Lancet editorial raised the question of whether the revival of locked wards should be considered (Lancet 1976). Often, the only secure facilities available to nurses for managing violence were lockable side rooms (Drinkwater 1982). Two small-scale studies of patients led to the recommendations that locked wards should be considered for patients difficult to mange on open wards (Cobb and Gossop 1976, Campbell and Mawson 1978). Others felt that necessary security could be provided without a return to locked wards and that these were not only of dubious therapeutic value but were ethically unjustifiable (Whitehead 1976). In response to difficulties managing all patients on open wards, some psychiatric hospitals introduced intensive care units that could be locked for patients regarded as too violent to be cared for on open wards (e.g. Mounsey 1979).

2.4.2 Placing patients needing less security

The lack of secure facilities and staff expertise and a growing reluctance to care for patients who were violent were identified as creating difficulties in placing patients no longer requiring the security provided by Special Hospitals but regarded as difficult, 'especially if this expresses itself in violent form' (MacCulloch 1977, p.62, Dell 1980). Provision of facilities for these 'difficult to place' patients saw expression in the secure unit programme. The Glancy report (DHSS 1974) and the Butler report (Home Office

and DHSS 1975) provided the impetus for this programme (Mercer and Mason 1998). The main recommendation made by the Butler Committee was to develop medium secure facilities, initially as interim secure units attached to psychiatric hospitals, to be followed later by regional secure units (Home Office and DHSS 1975).

Although a few secure units were established by the early 1980s, implementation was much slower than had been planned. Reasons for delays included: Regional Health authorities directing the money elsewhere (Drinkwater 1982, Mercer and Mason 1998); difficulties in recruiting suitably trained nursing staff (Drinkwater 1982, Berry and Freeman 1987); difficulty in obtaining the agreement of nursing staff and local residents (Drinkwater 1982); and ambiguity over categories of patients to be admitted (Drinkwater 1982). MacCulloch (1977) observed that while the new regional secure units would contribute to alleviating the problem of placement, some local facilities would still be needed.

2.4.3 District general hospitals

Some early trends noted in the development of psychiatric units in District General Hospitals subsequently became relevant to the incidence of violence in these units (Section 2.7). These units were envisaged as forming an integral part of revised mental health services and providing day and in-patient care (Ministry of Health 1961). Concern focused initially on slowness of provision (Ministry of Health 1968, DHSS 1975). Subsequent discussion focused on the mix of patients. Thus questions were raised over whether needs of psychotic and neurotic patients could be adequately met when both groups were nursed in the same ward (Raphael 1974, MacIlwaine 1981). The appropriateness of placing patients requiring long-term care in these units was also questioned: they were regarded as needing care and treatment in a different environment from those in an acute phase of their illness, and the units had been intended for short-term care, not for long-term patients who would block beds needed for acutely ill patients (Raphael 1974, Ferguson 1992).

2.4.4 Placing particular patients

Throughout the period reviewed thus far, there were two, often contentious, issues concerning the placement of patients that were relevant to nurses' views and experiences in relation to violence. Firstly, the assessment of dangerousness,

subsequently referred to as assessment of risk. was primarily of concern in decision-making about transferring patients to settings with lower levels of security and then into the community (Rubin 1972. Scott 1977). Concerns focused primarily on public safety although the question of staff safety had also been raised in the context of admission policies to psychiatric settings (DHSS 1976).

The second issue was that of placement of patients diagnosed as having a personality disorder. Folkard (1960), reviewing pre-conditions of the open door policy, observed that there was considerable difficulty in managing aggressive psychopathic patients under a permissive regime and posed the question of whether the open door policy could only function if these patients were cared for in locked wards. As observed earlier, COHSE (1977) expressed the view that psychopaths should not be admitted to ordinary psychiatric hospitals. In 1977, MacCulloch, then Principal Medical Officer at the DHSS, acknowledged that placement of psychopathic patients in ordinary psychiatric hospitals was particularly problematic. He maintained that there was no clear evidence that they were ill in the medical sense, nor that physical or psychological measures could change their state, and that many 'remain beyond change and prone to be both violent and dangerous' (MacCulloch 1977, p.60).

2.5 THE 1983 MENTAL HEALTH ACT

The mid 1980s saw the introduction of the 1983 Mental Health Act that placed increased emphasis on patients' rights and freedoms (Psychiatric Nurses Association 1983). The Act required hospital managers to inform patients of their legal status and to ensure they understood what it entailed, but nurses observed that such staff had neither the time nor expertise to do so and that it was nurses who had the requisite skills (Psychiatric Nurses Association 1983). The Act also made provision for registered mental nurses to invoke a holding power of up to six hours to detain patients already in hospital on an informal basis if regarded as necessary for their health or safety or for the protection of others, during which time necessary certification could be obtained from the patient's consultant or his nominated deputy (Hussain and Varadaraj 1983).

2.6 CONCERNS IN THE MID 1980s

By the mid 1980s there was considerable concern about violence among the mental health nursing profession and those responsible for provision of services. Changing philosophies of care and lack of progress in developing new services had led to difficulties in placing certain groups of patients, particularly those regarded as violent. Although guidelines had been produced at national and local level, concern remained about nursing competence in preventing and managing violence and its lack had led to injuries to staff and patients and to criminal prosecution of some employees, usually nurses. My study, therefore, took place at a time of concern about violence in psychiatric settings. There was also growing concern about violence in a wide range of healthcare settings and in 1985 the Health and Safety Commission undertook a survey of violence in all occupational groups in the health service (Health Services Advisory Committee (HSAC) 1987).

The foregoing review contributed to the development of the initial conceptual framework for my study (Section 4.3.2). The following sections focus on developments since the completion of fieldwork for my study. The overall policy direction for the provision of mental health services and progress made is discussed in Section 2.7 and violence within this context in Section 2.8. Subsequent sections focus on: developments in aspects of the role and education of nurses that were relevant to violence (Section 2.9); recent campaigns about violence in healthcare settings and the production of more guidelines (Section 2.10); and continuing concerns (Section 2.11).

2.7 SERVICE DEVELOPMENT: POLICIES AND PROGRESS

The overall policy for the provision of mental health services continued to be one of a mix of locally based health and social care services provided through primary care teams, specialist services, local authorities and, increasingly, other providers (SNMAC 1988, DH 1997a). In-patient services would increasingly shift to psychiatric units in District General Hospitals as large psychiatric hospitals closed. 24-hour-nursed beds would be provided for severely mentally ill patients requiring long term care. Residential accommodation would be available in the community for those discharged from hospital with an increasing range of organisations involved in provision. Day hospitals or centres would be available for those living at home or in community

settings. Community mental health teams would provide ongoing support and crisis intervention and resolution at home and, increasingly, at community mental health centres. While progress was made with all these developments (e.g. DH 1994) various commentators provided analyses of the ways in which policy objectives were failing to be fully achieved.

The population of the large mental hospitals continued to decrease as patients were moved to community facilities, falling from 130,000 in 1968 to just over 60,000 by 1988 (SNMAC 1988). There was, however, increasing recognition of a continuing need for hospital provision (DH 1989). The remaining long-stay patients were those with more serious problems, many requiring 24-hour medical and nursing care, and admission rates increased for new, acutely ill patients requiring intensive care (Jones 1987).

Problems arose, however, in providing appropriate in-patient provision for both these groups, plus a new group of patients requiring long-term care. Firstly, the policy of developing psychiatric units in district general hospitals was slow in being implemented (O'Donnell 1989). Secondly, in those units that had been established there were concerns about the impact of the patient mix on the quality of care staff could provide (DH 1994). The aim of the units was to provide short-term care for acutely ill patients but they were also admitting a new group of patients who required long-term care and blocked beds for new admissions. A team reviewing mental health nursing in the mid 1990s found that staff were concerned that increases in admissions of those with drug related problems and aggressive and challenging behaviour meant that the units had serious deficiencies as therapeutic environments (DH 1994).

Reviews of the community care policy noted that provision of resources had not kept pace with the programme of discharge (Jones 1987, O'Donnell 1989). While local authorities and a range of both private and voluntary providers in the independent sector were providing residential places, these were insufficient to meet demand (O'Donnell 1989). Recognition of the need for individually tailored care programmes for people with severe mental illness newly accepted by specialist mental health services and for people about to be discharged from a mental health hospital, led to the introduction of the Care Programme Approach (CPA) in 1991. A key worker for each such patient had

the responsibility of bringing resources and personnel together as appropriate and mental health nurses were increasingly nominated for this role (DH 1994). Concern about lack of coordination of care in the community for people with a severe mental illness identified as posing a risk to themselves through suicide or self neglect or to others through violence, led to the introduction of supervision registers in 1994 to ensure that they received effective and appropriate care (DH 1997a).

By 1997 the Royal College of Psychiatrists (RCP) regarded mental health services as in crisis and called on the incoming government to address the problem as a matter of urgency (RCP 1997). The essence of their argument was that community care policy had focused primarily on resettling long-stay patients in community settings and that far too little attention had focused on providing adequate services for the new generation of severely mentally ill people. There were insufficient numbers of 24-hour-nursed beds; consequently patients requiring this type of care were either not cared for at all or were in acute admission units, contributing to an unacceptably high level of bed occupancy (RCP 1997). Moreover, there were insufficient acute admission beds and the College argued that too many beds had been closed without replacement elsewhere. They maintained that hostels for those discharged from hospital had insufficient staffing levels and that some staff had inadequate training for meeting the needs of severely mentally ill people; and that there were insufficient community psychiatric nurses. Other concerns were: shortages of staff in all mental health professions; lack of availability to patients of certain therapies and techniques due to lack of staff training; and poor collaboration between the NHS and local authorities over service provision. High levels of violence were reported on many acute wards and the College felt that staff were working with intolerable levels of risk in many parts of the country (RCP 1997).

The Labour government's plans for the NHS made clear that mental health services would be a priority (DH 1997b). As such it was the focus of one of the national service frameworks: these were the mechanism through which the NHS would set out and achieve common standards across the country (DH 1998a). A blueprint for future mental health services was published at the end of 1998 (DH 1998b) and the National Service framework appeared the following year (DH 1999a). Mental health services featured prominently in the plan for the NHS as a whole (DH 2000). A final report on

action to translate the workforce implications of the national service framework into practice appeared in 2001 and included reference to workforce training needs in handling of verbal and physical abuse (DH 2001).

Noting that most large psychiatric hospitals had closed, or were set to do so shortly, and in light of the lack and inappropriate use of beds in acute in-patient settings, policies focused on addressing gaps in current services, in particular more 24-hour-nursed beds (DH 1999a). In the long term, however, pressure on acute and long-term beds was to be reduced by intervening early through crisis resolution, home treatment and, in particular, early intervention in psychosis in young people (DH 2000, 2001). In relation to secure facilities, the same problems identified in the 1970s remained: a shortage of locally provided secure places meant that some patients requiring a secure place were cared for in acute units, further adding to pressures in these units; and patients in Special Hospitals needing a less secure environment could not be found one at the appropriate level of security (DH 1998b).

2.8 PROBLEMS OF VIOLENCE

Following the above overview of developments in service provision, this section focuses on ways in which violence continued to be perceived as a problem. The 1985 survey had shown that violence was most likely to be experienced by staff in psychiatric settings (HSAC 1987). Recommendations were made on the same topics that had been covered in the guidelines of the 1970s. Central coordination was advocated for provision of training with involvement by the health departments, professional bodies, the NHS Training Authority and the Health Services Advisory Committee. Strategies to prevent and reduce violence focused on: the working environment; adequate information being available to all involved with patients; procedures to afford more protection to staff making community and domiciliary visits; and assessment of staffing levels. Procedures for managing violence included security systems to summon help and physical measures of restraint and self-defence. Post-incident procedures included reporting, support for staff and legal assistance and compensation.

Subsequently, several reviews of acute in-patient settings, based both in remaining large mental hospitals and in the psychiatric units of district general hospitals, identified a

range of problems that included risks of violence to staff and patients. The reviews included: an interview and observation study of eleven acute in-patient settings (Higgens *et al.* 1996); a one-day visit by members of the Mental Health Act Commission to 47% of acute psychiatric wards (The Mental Health Act Commission and the Sainsbury Centre for Mental Health 1997): and a study of patients from admission to discharge in a representative selection of nine hospitals (The Sainsbury Centre for Mental Health 1998). Another source of information was a review of nursing in acute units; this was based on a literature review, studies of nursing practice in relation to aggression and violence, and consultation with users, carers and health care professionals (SNMAC 1999). Information also emerged from an investigation of recruitment and retention of mental health staff (The Sainsbury Centre for Mental Health 2000) and an audit of standards in in-patient settings (RCP 2001).

A range of problems was identified many of which were regarded as conducive to violence. The following summarises the overall picture that emerged, each point having been made in most but not all the reports. Bed occupancy levels were often above those regarded as safe or reasonable, and there was a shortage of accommodation into which patients requiring long-term care could be transferred. There were increasing proportions of detained patients, of admissions in which violence was associated with drug or alcohol misuse, and of patients regarded as likely to present a risk to themselves, other patients and staff. Environments were often poor, with lack of space for privacy and lack of security for patients and their possessions. There was sometimes lack of clarity about the role of the unit and what it should offer service users. Patients often had little involvement in therapeutic or recreational activities and staff did not always have time or skills to provide appropriate interventions. Staff were given insufficient resources to advance the therapeutic aspects of care and some units were becoming more custodial in atmosphere. There were staff shortages and, in relation to nurses, the Standing Nursing and Midwifery Advisory Committee report observed that poor working conditions and lack of career opportunities contributed to problems of recruitment and retention (SNMAC 1999).

There were high levels of violence in many units with assaults on staff and other patients. The SNMAC (1999) report concluded that staff lacked skills in risk assessment and the management of aggression and violence and that there was a lack of

standardisation and quality control over courses in techniques of control and restraint. Nurses were often unclear about their legal position in relation to their right to search patients and to prosecute them for assault (SNMAC 1999). By 1999 the problem of violence for nurses working in acute in-patient units was of such concern that the UKCC undertook a major review of the problem, although this also included secure settings as well as ordinary psychiatric units.

The extent to which violence was also a problem for staff working in community settings emerged from a study undertaken by the University of Nottingham and reported in guidelines (Royal College of Nursing, NHS Executive 1998). The focus on community staff was in recognition that they often work alone, away from the support of colleagues or hospital security systems, and are thus particularly vulnerable. The work included a review of research and policy documents, and interviews with 158 employees from 17 trusts (Royal College of Nursing, NHS Executive 1998). The focus was on all community staff, not just nurses, and the guidance addressed incidents occurring when travelling to and from patients' homes, incidents involving recipients of the service, and bullying and harassment from other employees.

Turning specifically to community psychiatric nurses, having to work with clients with a known history of violence emerged among the top ten stressors in a study of stress among these staff (Carson *et al.* 1995). A study of community psychiatric nurses by Doyle (1996) revealed that they lacked appropriate training in assessing the likelihood of violence. Such assessments had become of increasing importance following government guidelines on the discharge and subsequent supervision and care of people with serious mental illness. Interviewees reported that they rarely used formal methods and rather relied on gut feeling and experience. If training had been received at either pre- or post-registration level it was regarded as inadequate (Doyle 1996). The introduction of the Mental Health Patients in the Community Act (1995) meant that community psychiatric nurses became involved in the process of compulsory detention of patients: Chaplin and Ellison (1998) and Clark and Bowers (2000) drew attention to this as a possible cause of violence directed towards these staff.

2.9 ASPECTS OF NURSING ROLES AND EDUCATION: 1987 ONWARDS

Since the fieldwork for my study was completed there have been changes in pre-registration nurse education. increased opportunities for continuing professional development and debate about the role of nurses in mental health services. This section discusses these developments as they pertain to violence in psychiatric settings.

By the early 1990s, the traditional routes to qualification as an enrolled or registered mental health nurse had been replaced by diploma programmes. All students undertook a Common Foundation Programme and then a branch programme in their specialism of choice. The mental health branch programme was based substantially on the 1982 syllabus (DH 1994). Benefits of the new programme were acknowledged but concerns were expressed about the following: the extent to which the new course prepared students to work in mental health settings (DH 1994, Higgens *et al.* 1996); too great an emphasis on general nursing at the outset inhibiting the development of core mental health skills (DH 1994); and clinical placements that were often too short to be educationally valuable (DH 1994). Considerable emphasis was placed in the 1990s on the importance of continuing education for all nurses (UKCC 1990, 1993, 1999, DH 1999b). Concerns about such opportunities for mental health nurses focused on lack of overall course provision (DH 1994) and constraints of time and funding on attending those courses that were available (DH 1994, Higgens *et al.* 1996, The Sainsbury Centre for Mental Health 2000).

In relation to acute settings there was concern that the role for which nurses were being trained was inappropriate to contemporary services. The focus had been on the nurse-patient relationship as the key therapeutic element of care, with an emphasis on counselling and continuity of care (for example JCMHO 1986, SNMAC 1988, DH 1994). Now, it was argued, emphasis was needed on, for example, the management of crises, anger, auditory hallucinations, and relapse (Higgens *et al.* 1996, The Mental Health Act Commission and Sainsbury Centre for Mental Health 1997, SNMAC 1999). The changing role of the acute ward appeared to be at odds with the model of care with which nurses had been traditionally trained and were still being trained (SNMAC 1999).

Additionally, practical experience of acute wards was often lacking during training. Newly qualified staff were thus largely unprepared for the situations they encountered in

practice. hence needed considerable supervision during their first six to nine months in post (Higgens *et al.* 1996). Few post-registration opportunities were identified for nurses working in acute settings and they lacked training in many of the interventions now regarded as desirable for care in acute settings (SNMAC 1999). The education situation was summarised as one of a gap between the university and service sectors that meant education and training were often irrelevant to the needs of contemporary services. Lecturers lacked robust clinical experience and there was a need for more work-based training so that skills could be taught in the clinical setting (SNMAC 1999).

A range of approaches to managing aggression and violence were, however, developed during this period upon which nurses could draw. These included techniques to de-escalate situations without recourse to restraint and breakaway techniques to enable escape without injury, as well as control and restraint techniques to prevent patients from harming themselves, other patients and staff (Leadbetter and Paterson 1995). Nevertheless, studies of acute settings concluded that many nurses were not trained in these techniques (Wright *et al.* 2002).

During the 1990s, increasing emphasis was placed on the importance of clinical supervision for mental health nurses (Barker 1994). Although the purpose of this form of support did not specifically focus on violence, there was recognition that it could have an important role in helping staff cope with stressful situations. Several reviews and surveys, however, showed that provision was not universal. The 1994 review of mental health nursing showed that adequate clinical supervision was not the norm for most mental health nurses (DH 1994) and a review of the roles of CPNs in the South West Region showed that not all were in receipt of supervision (South West NHS 1991). In acute settings, Higgins *et al.* (1996) found that although policies were in place for supervision to be provided, senior nurses at many sites reported difficulties in finding time to do so.

2.10 CAMPAIGNS AND GUIDELINES ON VIOLENCE

The foregoing sections have indicated that violence in psychiatric settings remained a matter of concern. From the late 1990s onwards there have been several high profile campaigns about violence in healthcare generally and several new sets of guidelines

have been produced. Concurrently new guidelines were also developed specifically for staff working in the mental health services.

2.10.1 Violence in all healthcare settings

During 1998 the Royal College of Nursing was involved jointly with a weekly publication, *Nursing Times*, in a campaign entitled *Stamp out Violence*. Based on a survey of nurses' experiences of violence (Coombes 1998), the campaign was premised on the view that violence in the form of either verbal aggression or physical assault was unacceptable. The same year, the Royal College of Nursing, jointly with the NHS executive, published a guide on safer working in the community based on commissioned work undertaken by the University of Nottingham (RCN, NHSE 1998).

Reducing violence to staff was included in the human resources strategy of better valuing staff that the new Labour government stated would be a key component of delivering the reforms envisaged for the NHS (DH 1997b). Performance targets to reduce violence were set (DH 1998c, 1999c). In *Making a Difference* which sets out government strategy for the future of nursing, midwifery and health visiting, it was reiterated that violence to staff was regarded as completely unacceptable, particularly the perverse notion that it 'goes with the job' (DH 1999b).

A survey of all trusts showed that nurses were the group of staff most likely to be involved in violent incidents and that trusts for mental health/learning disability services recorded the highest average figure (Government Statistical Service 1999). Most (96%) of trusts had some form of violence reduction scheme that included staff training, increased physical security systems and better monitoring of violent incidents to help raise awareness and reduce likelihood of incidents occurring. In late 1999, the government launched a campaign against aggression, violence and threatening behaviour entitled Zero Tolerance and employers were sent a resource pack containing publicity materials and guidance for managers and staff on their prevention (NHSE 2000).

Despite all these initiatives violence in healthcare settings remains of concern. This has recently been evidenced in that the NHS Counter Fraud and Security Management Service, charged with tackling violence against NHS staff, announced that all Trusts

will be expected to provide training for all their front-line staff to help them deal with attacks from patients (Nursing Times 2003).

2.10. 2 Guidance on violence in mental health settings

i) Organisational responses

There was no shortage of guidance on the subject of violence for those responsible for, or working in, mental health settings from the late 1990s onwards. In 1997, the Royal College of Nursing produced guidance aimed primarily at mental health nurses and managers (RCN 1997). In 1998, the Royal College of Psychiatrists produced guidelines on the management of violence for staff working in mental health in-patient settings (RCP 1998). Sources for the latter's conclusions included a review of available evidence for managing violence, and discussion groups in which nurses, service users and carers expressed their views on dealing with violence (McMillan 1998). In 2000, as part of its Zero Tolerance campaign, the government developed resource sheets to support staff working in settings where the risk was greatest, identified as in mental health and ambulance services and in the community (NHSE 2000). In 2002, the UKCC produced its report *The recognition, prevention and therapeutic management of violence in mental health care* (UKCC 2002a). The outcome of a three-year project that involved reviewing literature, intensive consultation and commissioned research, the final report contained guidance and recommendations for future action and research (UKCC 2002a). While the review focused on adult acute wards, intensive care and forensic settings, the summary report for dissemination observed that the findings were also applicable to other mental health settings, community and residential, as well to other healthcare settings such as accident and emergency departments (UKCC 2002b).

ii) Recommendations

All four documents discussed reasons for violence, focusing in varying degrees of detail on aspects of mental illness and a range of environmental factors. Guidance was given on ways to improve a range of factors that would reduce the likelihood of violence: staff availability to patients; quality of the physical environment; availability of recreational facilities; and security of access. The documents all recommended that information about violence in patients' histories be readily available to all those involved in their care. The documents all considered risk assessment. The RCP (1998) stated that there was insufficient evidence to formulate precise guidelines but suggested a range of

demographic, clinical and situational variables that they regarded as relevant to assessment.

All four documents discussed verbal and non-verbal techniques of de-escalating aggression and details of procedures to adopt when these were unsuccessful (physical restraint, seclusion and medication). All four documents also placed great emphasis on training for all staff in breakaway and de-escalation techniques, training in physical restraint for clinical staff and the responsibility of managers for assessing staff training needs. Attention was drawn to the importance of staff having their skills regularly updated (RCN 1997, NHSE 2000). The UKCC (2002a) stressed the importance of accreditation of course teachers, since their own survey had revealed little systematic evidence of qualifications held by trainers. Both the RCN (1977) and the UKCC (2002a) stated that there was a need for research to identify effective and efficient methods of managing aggressive and violent individuals.

Reference was made to post-incident review in all documents, with the RCN (1997) and RCP (1998) focusing on this as a means whereby lessons might be learnt. Support for staff following an incident was universally recommended, although the National Health Service Executive (NHSE 2000) drew attention to evidence indicating that this was not always helpful, hence it was important to assess whether it was appropriate in individual cases. The NHSE (2000) and UKCC (2002a) considered in some detail the issues surrounding the prosecution of patients who assaulted staff.

The UKCC (2002a) stressed that the problem of violence required a cohesive, multifaceted organisational approach. In varying degrees of detail, all documents focused on responsibilities of managers to create safer working environments. The RCN (1997) maintained that providers had a responsibility to ensure that adequate staffing and skill mix were available in settings where restraint might be indicated and the RCP (1998) advocated regular audits of violent incidents including available staffing levels and skill mix.

The NHSE (2000) stated that their Zero Tolerance policy applied to mental health as well as to other settings. The UKCC observed that the Zero Tolerance policy presented them with a dilemma in the course of undertaking their review:

> *'On the one hand, there is a clear duty to protect staff and the general public and vigorously to pursue legal action against the perpetrators of violence. On the other hand, mentally ill people may perpetrate violent acts through no fault of their own.' (UKCC 2002b p.3)*

2.11 CONTINUING CONCERNS

Developments since completion of fieldwork for my study show that violence has remained a matter of concern for the mental health nursing profession and those responsible for the provision of services. This last section draws together key themes in the periods before and after the study. The need for guidelines appears to have remained undiminished with four sets produced in the 1970s and likewise in the 1990s. There have been continuing difficulties in placing certain groups of patients, particularly those regarded as presenting problems in terms of violence. The importance of training and development of skills has been a major emphasis throughout and, while a range of new courses to develop skills is now available, there is still recognition that much more training is needed. From the early days of nurse training, the view has been expressed that the influence of general nursing on pre-registration nurse education has inhibited the development of mental health nursing skills; recently this has focused on preparation for work in acute settings and challenging situations.

The guidelines in both periods had highlighted nurses' concerns about the balance of patients' and nurses' rights and safety in relation to violence. That such concerns remain is suggested by a recent review of mental health staffing issues. Nurses who were interviewed felt that their welfare and safety were not given adequate attention, there was an imbalance between patients' and nurses' rights, and nurses were expected to accept being assaulted (Sainsbury Centre for Mental Health 2000). Such an approach to staff was identified as contributing to attrition from the service, further exacerbating short-staffing (Sainsbury Centre for Mental Health 2000). Staff concerns in this respect, however, occur in contexts of complexity and inconsistency in the law regarding assault and self-defence (Wright 1999) and of conflicts between the culture of caring for patients and prosecuting patients for violent or antisocial behaviour (Till 1998).

Patients diagnosed as having a personality disorder were identified as difficult to place in the period prior to the study and some expressed the view that these patients should not be placed in ordinary psychiatric hospitals (COHSE 1977). Debate concerning appropriate placement and treatment of these patients has continued (for example, Moran and Mason 1996, Manning 2000, Woods and Richards 2003). The Royal College of Psychiatrists has argued that consideration be given to removing personality disorder from mental health legislation (RCP 1997). Part of the rationale for the development of a new Mental Health Act has been that neither mental health nor criminal justice law currently provides a robust way of managing the small number of dangerous people with severe personality disorder, and that a more effective framework for assessment and management is needed (DH 2001). Mental health professions, however, have expressed considerable concern about these proposals on grounds that they infringe patients' civil liberties (Holdsworth and Dodgson 2003).

Both the early and the later guidelines stressed the importance of holding discussions after incidents as a means of learning how to improve prevention and management rather than as means of attributing blame to individuals. It has been argued, however, that a culture of blame persists, not only in mental health but in public life generally, and that formal enquiries into adverse incidents focus on individual failings rather than those of the organisation as a whole (e.g. RCP 1997, Vincent *et al.* 2000, Benson *et al.* 2003). Such a culture leads to defensive practice and increasing anxieties about how risk should be managed. This can result in conflict between empowering people to take risks and legal and cultural environments that focus on possible punishments when adverse events occur, a conflict felt most acutely by front-line staff (Sainsbury Centre for Mental Health 2000).

This review of policy developments revealed that a wide range of factors has been regarded as relevant to nurses' roles and education concerning the incidence of violence in psychiatric settings. My study focused on nurses' experiences and views in this respect and the next chapter reviews research relevant to this subject.

CHAPTER 3: RESEARCH INTO NURSES' EXPERIENCES AND VIEWS IN RELATION TO VIOLENCE

The early sections of this chapter (3.1 to 3.9) discuss the research I reviewed prior to starting fieldwork and which contributed to the development of a conceptual framework to guide data collection (Section 4.3.2). Section 3.10 describes the approach I have taken to the subsequent literature in the field and this literature is discussed in Sections 3.11 to 3.16.

3.1 RESEARCH PRIOR TO MY STUDY

Research undertaken prior to the fieldwork that provided findings on nurses' views and experiences of violence was primarily of two kinds: studies of violent incidents and studies of nurses' views about particular aspects of violence. This section discusses the aims and methods of these studies.

3.1.1 Aims of incident studies (prior to 1987)

Of those studies that investigated violent incidents, some sought to identify whether associations existed between the characteristics of certain patients and/or staff and the prevalence of incidents. Other studies focused on specific aspects of ward management and the incidence of violence.

i) Aims of profile studies

In an early study, Folkard (1960) assessed the impact on the incidence of assaults of unlocking a ward for 50 disturbed female patients. Subsequent studies included a six-month study investigating accidents, including violent incidents, sustained by all patients and staff in most services of a psychiatric hospital (Leopoldt *et al.* 1978, Hawton and Leopoldt 1978); a nine-month study of two open and two locked wards for male patients (Fottrell *et al.* 1978); a 12-month study in all services of two psychiatric hospitals and for four months in an inpatient unit of a district general hospital (Fottrell 1980); incidents in all services of psychiatric hospitals over four months (Caseem 1984) and three years (Hodgkinson *et al.* 1985). A one-year study of incidents in all settings of a psychiatric hospital, excluding the regional secure unit, was undertaken by Pearson

et al. (1986) and a six-month study of a 16-bed, mixed sex, acute unit by Convey (1986).

ii) Aims of specific aspect studies

Studies focusing on a specific aspect of violent incidents included: a four-week study of four wards for chronic patients investigating the relationship between the incidence of disturbed behaviour and the integrity of the nursing staffing system (Torpy 1972); an 18-month study to identify causes of disturbed behaviour that were related to the psychological environment in a locked ward for 23 male patients (Weaver *et al.* 1978a); a 90-week study of the relationship between frequency and severity of incidents and administrative changes in a semi-secure ward (Armond 1982); and a six-month study of factors that might predict violent assaults by patients on staff on a mixed sex, 17-bed locked ward (Aiken 1984).

3.1.2 Methods adopted for incident studies (prior to 1987)

The studies differed over the types of events defined as incidents to be included, making it difficult to draw cross-study conclusions (Drinkwater 1982). Only some of the authors discussed problems in the interpretation of their findings, given flaws in their methods of data collection and analysis.

i) Criteria for incidents included in the studies

Two studies included only assaults on staff (Aiken 1984 and Hodgkinson *et al.* 1985). One focused on accidents to staff that included assaults by patients (Leopoldt *et al.* 1978). Other studies included verbal aggression, physical assault on others (staff and patients) and damage to property (Folkard 1960, Torpy 1972, Fottrell *et al.* 1978, Armond 1982, Casseem 1984, Convey 1986, Pearson *et al.* 1986). Self harm was also included in the studies by Fottrell *et al.* (1978) and Casseem (1984) and behaviour described as being disturbed, noisy or difficult in some way was included by Torpy (1972).

ii) Data collection and analysis

Most studies used standard hospital violent incident records (Leopoldt *et al.* 1978, Fottrell *et al.*1978, Armond 1982, Aiken 1984, Casseem 1984, Hodgkinson *et al.* 1985, Pearson *et al.* 1986, Convey 1986) although concerns were expressed about their

completeness and accuracy. Drawing on their own experience, some authors observed that there was under-reporting, for reasons such as: incidents being too minor to be worth the administrative work involved (Casseem 1984, Hodgkinson *et al.* 1985). Possible reasons for lack of accuracy included report completion being delayed or written by others not present during the event (Drinkwater 1982) and differing perceptions of the event, for example reports that stated 'nurse was helping patient' when the patient might have perceived this help as provocation (Casseem 1984).

Attempts to increase data accuracy included: researchers checking their contents with staff involved (Leopoldt *et al.* 1978); campaigns to raise staff awareness of the importance of accurate reporting (Fottrell *et al.* 1978, Fottrell 1980, Hodgkinson *et al.* 1985); and supplementation with nursing and/or medical records (Armond 1982). Some researchers developed instruments specifically for the study, to be completed by themselves or staff, (Fottrell 1980, Aiken 1984). Interviews with staff were included in the study by Aiken (1984) and with staff and patients in that by Armond (1982). Senior nursing and medical staff were asked to check that no incidents were omitted (Pearson *et al.* 1986). In the study undertaken by Convey (1986), staff were asked to complete an additional questionnaire to provide data about patients and qualitative descriptions of how incidents arose.

Most studies presented information on associations between the nature of incidents, their time and location and characteristics of patient and staff involved. Problems with data presentation included providing absolute frequencies for staff and patient variables rather than relating these to baseline data for staff and patient populations. The studies varied in this respect. Hodgkinson *et al.* (1985) and Pearson *et al.* (1986), for example, did relate their data to baseline figures. The study by Torpy (1972) involved correlating a weekly staff change score in terms of deviation from standard staffing with a weekly patient disturbance score from information in the daily nursing report sheets. Aiken (1984) rated three aspects of patients' behaviour immediately prior to assault (speech, activity and posture, and interpersonal distance) and correlated these data with scores for staff anticipation of the incident and the severity of assaults.

3.1.3 UK and non-UK literature on incidents

When reviewing the literature on incidents, I included both UK and non-UK studies. In considering how the findings of these studies might inform the development of the conceptual framework for my study (Section 4.3.2). I drew only on the UK studies. This was because settings in the UK studies appeared to differ substantially from those in the non-UK studies. Non-UK studies included the work of Ekblom (1970) in Sweden and Kalogerakis (1971), Depp (1976, 1983), Levy and Hartocollis (1976). Conn and Lion (1983) and Tardiff (1983) in the US. Since I was proposing to undertake a case study in a site in the UK, selected as far as possible to be typical of mental health services, I thought it preferable that the design be informed by the UK incident literature only. For reasons indicated below I did, however, include studies of staff views about their involvement in incidents.

3.1.4 Aims and methods of surveys of staff views (prior to 1987)

While views of staff in the above studies focused primarily on specific incidents, an early UK study by Brailsford and Stevenson (1973) sought staff views on how disturbed situations generally might be precipitated by the hospital environment or the interrelationships between staff and between staff and patients. The research instrument was a questionnaire, devised on the basis of discussion with colleagues and past experience, and comprised a series of statements to which respondents were asked to answer always, frequently, sometimes, seldom, or never. The questionnaire was distributed in two hospitals to as many nursing and medical personnel as possible and while the overall response rate is not provided it is possible to calculate that the maximum would have been 56%. Findings were presented separately for students (34), staff nurses (5), deputy (10), charge/sister (12), nursing officers (5) and doctors (7). While flawed in terms of not piloting the questionnaire nor providing details of response rates by grade, the study was nonetheless an early contribution to understanding nurses' views about violence and how these might differ between grades and from those of medical staff.

Three studies undertaken in the US were included in the review of studies concerned with staff views since the events investigated were those also likely to be experienced by staff in the UK. All three involved interviews with staff: DiFabio (1981) on the effects of being involved in restraint, and Lanza (1983) and Conn and Lion (1983) on

the effects of being assaulted. Having observed that nurses found restraint disturbing, DiFabio (1981) sought to understand why this might be the case by interviewing 15 nurses in acute settings who had been involved in placing patients in mechanical restraints. DiFabio (1981) observed that the subjects volunteered to participate and so might have been unrepresentative. The subjects were asked to recall thoughts, feelings, conversation and behaviour that occurred during each segment of the restraint. In response to finding no research on nurses' reactions to assault, Lanza (1983) undertook a questionnaire survey of 40 staff nurses and nursing assistants in one US neuro-psychiatric hospital who had been assaulted. The study participants were asked about their short-term (up to a week) and long-term (week to a year) emotional, social and bio-physiological reactions to the last-reported assault and any previous assaults, using a five point scale from no response to severe response. The author observed that the results might not be generalisable since the sample was small and the data were subject to recall (Lanza 1983). A study undertaken by Conn and Lion (1983) included interviews with staff who had been seriously injured during violent incidents.

3.1.5 Presentation of findings of studies (prior to 1987)

Reviewing the above studies contributed to the development of the conceptual framework that guided data collection (Section 4.3.2). The findings of the above studies are therefore presented as they related to the developing framework: patterns of incidence, involvement and injury (Section 3.2); aspects of the service (Section 3.3); the interpersonal environment (Section 3.4); programme of care (Section 3.5); prevention and management of violence (Section 3.6); post-incident events (Section 3.7); effects on staff and organisations (Section 3.8); and education (Section 3.9). Some studies contributed findings to just one of these sections, others to two or more.

3.2 INCIDENCE, INVOLVEMENT AND INJURY

3.2.1 Variations in incidence by service

Most of the studies focused on acute services only. Those that encompassed other services provided separate details for each. Fottrell (1980) found that incidents were most likely to occur on the locked intensive care ward, the acute admission wards and the drug dependence ward. Likewise, Hodgkinson *et al.* (1985) reported highest

incidence in the locked, intensive care ward followed by most of the acute admission wards, although one long-stay chronic ward had the second highest incidence. Moreover, Hodgkinson *et al.* (1985) found that the increase in incidents overall during the study period was attributable to a rise in incidence on the intensive care ward and admission wards. Leopoldt *et al.* (1978), however, found that the incidence was higher in the long-stay rehabilitation wards than in the acute wards, although noted that incidents on the latter were likely to be more serious, and that there were very few in the specialist units (therapeutic community, and alcohol and drug dependence). Pearson *et al.* 1986 reported an excess, as expected, on acute wards but an unexpected excess on continuing care wards. Arguing that this latter finding merited further investigation, the authors suggested it might be attributable to patients with schizophrenia whose symptoms were resistant to medication.

3.2.2 Incidence by occupational group

Those studies that included all occupational groups in the setting showed that nursing staff were most likely to be the recorded victims of incidents (Fottrell 1980, Armond 1982, Aiken 1984, Casseem 1984, Hodgkinson *et al.* 1985, Convey 1986). Some studies sought to ascertain whether there were differences by age, sex and grade of staff. When numbers were standardised for base numbers no differences were found by age of staff assaulted (Leopoldt *et al.* 1978) and gender of staff assaulted (Leopoldt *et al.* 1978, Hodgkinson *et al.* 1985). Figures provided by Aiken (1984) however, suggested that female staff were more likely to be assaulted than male.

3.2.3 Grade

Leopoldt *et al.* (1978) found a proportionally higher rate of assault among unqualified than qualified staff. Qualified staff thought this was because the unqualified staff lacked training; the unqualified staff attributed it to spending more time with patients. That nursing auxiliaries spent more time with patients than registered nurses emerged from a study of the amount of time spent in different activities by each grade of staff (Broome and Weaver 1978). Arguing that training was likely to contribute to skills in anticipating and preventing potentially violent behaviour, Leopoldt *et al.* (1978) emphasised the need for unqualified staff to receive training in this respect.

A more detailed breakdown by grade, also corrected for base numbers. was provided by Hodgkinson *et al.* (1985) together with suggestions as to why levels for each grade might differ. That learners were assaulted more often than expected might be due to: relative inexperience; possibly being less circumspect; and moving from one ward to another, which militated against gaining sufficient knowledge of patients to recognise warning signs. Contrary to the findings of Leopoldt *et al.* (1978), nursing auxiliaries were assaulted less often than expected. Hodgkinson *et al.* (1985) also suggested that as nursing auxiliaries were often a stable and long serving population, they were more likely to know patients and avoid situations that increased the risk of assaults. Moreover they might also be expected not to confront patients. Enrolled nurses were assaulted as often as expected. It was observed that enrolled nurses also were a stable and long serving group but were regarded as having greater ward responsibility than assistants. Staff nurses were assaulted more often than expected. As a mobile group they had less opportunity to know patients well but were often expected to take responsibility that entailed confronting patients, thus increasing their risk of assault. Nurses in charge were assaulted less often than expected. Although an experienced group, the nature of their responsibilities might result in less direct patient contact and thus a reduced risk of assault (Hodgkinson *et al.* 1985)

Convey (1986) reported that charge nurses and staff nurses were assaulted at the rate expected but that nursing assistants were assaulted more often; they comprised 10% of the workforce but encountered 34% of the attacks. She observed that while these staff frequently have more contact with patients than other staff, traditionally they have not been included in decision-making about patient care and thus may be unsure of the recommended approach to particular patients. Moreover, their training may cover practical management of violence but not verbal and non-verbal communication (Convey 1986).

Two studies found that some assaulted staff were involved in more incidents than others. Aiken (1984) reported that two staff were involved in three incidents each and one in six. Hodgkinson *et al.* (1985) reported that 5% of staff were involved in 20% of incidents and while this was largely accounted for by working in high-risk areas, the authors suggested that aspects of the preferred management style of these staff might have been a contributory factor.

3.2.4 Severity of injuries

Injuries sustained in incidents were assessed in several studies. In the main, none or only minor injuries were sustained. Some of these studies used a three-point grading system developed by Fottrell *et al.* (1978): no injury; minor injuries (small lacerations, bruises and abrasions); and major injuries (large lacerations, loss of blood, fractures, loss of consciousness and those requiring further investigation). All the studies of acute settings found that when injury was sustained it was more likely to have been of a minor than major nature (Fottrell *et al.* 1978, Armond 1982, Aiken 1984, Convey 1986). In the study by Aiken (1984), however, which investigated assaults to staff in a locked ward, attention was drawn to a higher rate of serious injuries than found in other studies of acute settings.

The same pattern was found in studies involving other services as well as acute. Using the Fottrell *et al.* 1978 system, Fottrell (1980) reported that three of the 424 incidents were graded as major and 14 as minor and Hodgkinson *et al.* (1985) and Pearson *et al.* (1986) that the vast proportion of assaults fell into the minor or no injury category. Leopoldt *et al.* (1978) classified 10% of injuries to staff as major (defined as resulting in loss of work), 61% as minor (defined as resulting in physical injury but no loss of work) and 29% as not resulting in injury. Only four of the 152 incidents required treatment other than a simple dressing in the study by Casseem (1984).

3.2.5 Patterns of patient involvement in incidents

Most of the incident studies reported a pattern of a small proportion of the patient population being involved in incidents and some of these patients being involved in a higher proportion of incidents than others. Analyses also focused on whether a profile of patients more likely to be involved in incidents than others, in terms of demographic characteristics and diagnostic category, could be determined from the data; conclusions have been reviewed extensively elsewhere (e.g. Whittington 1994).

3.3 ASPECTS OF THE SERVICE

3.3.1 Nature of the environment

In relation to locked wards, Folkard (1960) demonstrated a decrease in the number of incidents during a 10-week period when a ward was unlocked compared to the previous 10 weeks when it was not. The study had been undertaken in response to the view that unlocking wards would decrease the tension associated with being unable to leave (Folkard 1960). In a much later study of a locked ward, Aiken (1984) found that the commonest reason for incidents was friction over wanting to leave. Others who had studied incidents on locked wards suggested that this frustration contributed to the incidence of violence (Fottrell 1980, Weaver *et al.* 1978b).

Aspects of acute admission wards suggested as being conducive to violence included: patients admitted under compulsory order being prevented from leaving; acutely disturbed patients causing offence to other patients and the latter reacting violently; and the occasional locking of the ward (Fottrell 1980). Hodgkinson *et al.* (1985) suggested that policies of reducing the number of long-stay wards meant that patients were kept on admission wards for longer thereby keeping them under greater pressure. Leopoldt *et al.* (1978) attributed the high incidence on long-stay rehabilitation wards to difficulties in providing a truly therapeutic milieu and patients' resulting frustration, and contrasted this to the absence of incidents in the group homes or hostels to which long-stay patients had been discharged.

3.3.2 Ward design

On the basis of their studies, Casseem (1984) and Weaver *et al.* (1978b) argued that poor quality physical living conditions contributed to violence. Respondents participating in a survey of staff views argued that research was needed on environmental layout of wards to identify localities prone to incidents of violence and that there should be more consultation with nursing staff about ward design (Brailsford and Stevenson 1973).

3.3.3 Admissions policy

Several studies focused on aspects of admission policies. For Brailsford and Stevenson (1973) interest focused on nursing and medical staff views about decisions to admit

potentially violent patients. Most nursing and medical respondents thought that nursing staff should have influence in the decision to admit these patients: when asked whether this was the case, nursing staff were more likely to say sometimes, seldom or never whereas most doctors said always or frequently. Moreover, most nurse respondents said that decisions to admit such patients were not related to the level of skill and experience of nursing staff (Brailsford and Stevenson 1973).

Armond (1982) investigated changes in the incidence of violence during a period when patients were being moved between wards and there were changes in admission policy. Incidents were lowest when patients were moved to a larger ward with a controlled admission policy. Previously, medical and nursing staff on other wards had been allowed to admit patients to the semi-secure ward without reference to the ward's staff. These new patients could be disruptive of ward routine and Armond argued that this undermined the resident patients' feelings of security. The problems created by brief admissions of violent patients from other wards were also offered by Aiken (1984) as a possible explanation for increases in the incidence of violence.

3.3.4 Staffing

A consensus view that short staffing could contribute to the incidence of violence emerged from respondents in the Brailsford and Stevenson (1973) survey. One study specifically reported that shortage of nurses contributed to some of the incidents Armond (1982). Various studies have suggested that the incidence of violence is related to changes to the regular nursing staffing of the ward. Folkard (1960) found that the overall number of incidents decreased during the ten weeks when the ward was unlocked, but the level of incidents rose when one or both of the nursing sisters were absent during both the locked and the unlocked period. Likewise Weaver *et al.* (1978a) found that the level of violence on a locked ward decreased with the introduction of certain improvements but that some patients were upset during periods of irregular staffing. High patient disturbance scores for patients on four chronic wards were significantly correlated with high staff change scores, particularly when these changes were rapid (Torpy 1972).

3.4 INTERPERSONAL ENVIRONMENT

Aspects of the interpersonal environment included relationships between staff and patients and relationships between members of staff. (Relationships between patients are discussed in Section 3.5.)

3.4.1 Relationships between staff and patients

i) Nature of relationships

Respondents in the Brailsford and Stevenson (1973) survey observed that staff attitudes to patients were sometimes conducive to violence. These included being over-authoritative, offhand, superior, tactless, inhuman, harsh, rigid and disrespectful. These attitudes were attributed by respondents to staff insecurity, stifled initiative, the approaches to nurses of medical and other staff, lack of communication, frustration due to lack of ward policy, lack of praise and recognition, and feeling a lack of direction and motivation. Of the specific incident studies, while Leopoldt *et al.* (1978) stated that assaults on staff were entirely the result of aggression by patients, other authors considered whether staff might have contributed in some way. Those who had found that some staff were more likely to be involved in incidents than others suggested that this might indicate inappropriate interactions with patients (Aiken 1984, Hodgkinson *et al.* 1985).

ii) Staff expectations of violence

Staff expectations of patient violence were identified as contributing to its incidence (Fottrell 1980). Discussing this point, Hodgkinson (1980) argued that labelling patients as dangerous led to staff expectations that they will be violent; their consequent anxiety was communicated to patients, increasing patients' anxiety and the likelihood that they will be violent.

iii) Violence as a means of gaining attention

Violence as a means of gaining staff attention or achieving a desired outcome was also considered. Weaver *et al.* (1978a) observed that while the attention gained in the form of sedation or restraint may seem aversive, it may be the only attention that patients can gain. Likewise, Drinkwater (1982) concluded from a review of studies of staff-patient interaction that staff interacted less with more disturbed patients and suggested that violence may be the most effective way for such patients to gain attention. The

conclusion drawn from a study by Weaver *et al.* (1978a) of patterns of behaviour prior to an incident was that patients may be violent as a means of achieving a preferred outcome; for example, being placed in a side-room rather than going to work or being bullied by other patients.

3.4.2 Relationships between nursing staff and between nurses and other staff

Respondents in the study by Brailsford and Stevenson (1973) reported that there was prompt oral communication when emergencies occurred but thought that better use could be made by medical and nursing staff of written nursing notes and the Kardex system to facilitate anticipation of patient behaviour problems. Respondents' recommendations included increased discussion among ward staff to formulate policies and plans about patient care, and senior nursing staff and medical staff adopting a less authoritarian attitude to junior staff since this would reduce authoritarian behaviour by staff to patients. Another recommendation was stimulating better team spirit by, for example, increasing the follow up of constructive policy suggestions made by nursing staff since this would facilitate a more therapeutic ward atmosphere (Brailsford and Stevenson 1973).

3.5 PROGRAMME OF CARE

Loss of freedom through not being allowed to leave the ward had been identified as contributing to the incidence of violence (Section 3.3.1). Other aspects of what might be described as the programme of care included medication and activities. Disputes over medication were identified by Aiken (1984). Within an overall decline in violence when a preventative programme was implemented, Weaver *et al.* (1978b) found that incidents increased when patients' access to their worksite was withdrawn. Fottrell (1980) found fewer incidents in occupational and industrial therapy units than in the wards and suggested that situations when patients are together with little therapeutic activity are conducive to violence.

That the incidence of violence was higher at certain times than others emerged from several studies: during day rather than night (Fottrell 1980, Convey 1986, Pearson *et al.* 1986); at meal times (Fottrell 1980, Pearson *et al.* 1986); and in the morning (Fottrell 1980, Hodgkinson *et al.* 1985). Hodgkinson *et al.* (1985) suggested that these were

times when staff were busy with activities that were not directly patient centred and, although some patients were occupied off the wards, the most disturbed often remained and were likely to have their needs for attention frustrated.

Armond (1982) reported that in 16 of the incidents studied, patients were described as having reacted with violence to mild provocation such as being told that milk and cigarettes were running out, or being asked to return cigarettes that they had just snatched from someone else. Casseem (1984) found that 47% of incidents were between patients and in a third of these the incident report referred to interference, provocation or aggression; disputes over cigarettes featured frequently.

Another aspect of the programme of care that emerged from studies reviewed was the importance of staff observation and interpretation of patients' behaviour. Better anticipation by nursing and medical staff of patient behaviour problems was advocated by respondents in the survey undertaken by Brailsford and Stevenson (1973). The study by Aiken (1984) on factors that might predict assault investigated patient's arousal score (speech, activity and posture) and found that change in activity and posture were the signs most likely to lead to serious assault.

3.6 PREVENTION AND MANAGEMENT

Aiken (1984) reported that, with hindsight, staff thought that 26 of the 41 incidents in his study could have been prevented. Suggestions made by study participants for avoiding similar events included: taking control of the patient before rather than after violence occurred; avoiding confrontation with the patient and backing down if needs be; giving the patient more space; and organising the exact role for each member of staff when a potential incident is expected with only one member of staff doing the talking (Aiken 1984).

The study by DiFabio (1981) showed that nurses found restraint a highly emotional experience and that it often disturbed them because they had no help in dealing with their feelings, a wide range of which were identified. DiFabio (1981) recommended that nurses be prepared technically through having a concrete plan about when and how to restrain, and prepared emotionally through help with: feeling angry with patients;

concern that they might lose control: and perceived conflicts between nursing values and the experience of restraint.

Observations about the pressure that nurses may experience in relation to managing violence were made in several studies. Folkard (1960) found an increase in 'treatments' in response to disturbance when experienced staff were replaced by nurses new to the ward, and suggested that this reflected anxieties of the new nurses. Hodgkinson (1980) contended that the need to control often stems from staff fear of being blamed for incidents and not feeling adequately supported to try possible risky strategies.

Weaver *et al.* (1978b) argued that disturbed behaviour may become a 'fashion' on the ward and that staff, interpreting this as patients relapsing, may overreact with changes in medication policy and ward management. These, in turn, may give the fashion more status and prolong its duration. In similar vein, Hodgkinson (1980) considered that staff and patient behaviour have reciprocal effects; staff respond to anxieties caused by disturbed behaviour by excessive control of patients which, in turn, can worsen the disturbance.

3.7 POST-INCIDENT EVENTS

One of the studies reviewed, Aiken (1984), investigated subsequent discussion of incidents. Aiken found that of the 41 incidents 15 were not discussed, 20 were discussed informally and six discussed at a ward meeting. Of the 26 incidents regarded as avoidable by respondents, twelve were not discussed; Aiken (1984) suggested that this might be due to embarrassment if the staff involved felt they had erred. Aiken recommended that there should be a specific regular time when incidents could be discussed without recrimination since the lessons learned would be applicable to all staff.

Convey (1986) suggested that the practice of outlining precipitating factors for her study had made nurses aware of their own contribution to violent incident generation. She argued that it was important to record how incidents were prevented as well as recording those that had occurred, since the former would build up information about what are the preventive elements existing in wards.

3.8 EFFECT ON STAFF AND ORGANISATION

Several studies reported nurses' feelings in relation to violence generally and in relation to specific assaults. On the former, Brailsford and Stevenson (1973) found that respondents reported gravitating to the charge nurse / ward sister's office as a result of feelings of insecurity about a lack of a programme of care for patients and concern about their own inexperience and safety. They recommended better training in group methods as a means of relieving tension. Some information on the impact on staff victims of assault was provided in three studies: in the US by Conn and Lion (1983) and Lanza (1983) and in the UK by Aiken (1984).

Several outcomes emerged from the study by Conn and Lion (1983), in which interviews were held with those who were seriously injured in the course of incidents. Almost unanimously, victims said that the emotional impact was greater than the physical and that various psychological sequelae were experienced such as insomnia, eating disorders and depression. Victims became fearful of working with unpredictable or dangerous patients, in particular feeling hesitant to confront them or set limits. They experienced concerns and doubts about their own professional competence and how this would be viewed by colleagues. Victims reported needing time to express their feelings and opportunities to learn from the incident in a non-judgemental context. While all said that their need for emotional support after assault was enormous, experience differed over whether it had been available. Victims reported feeling angry with the patients who assaulted them and angry with the administration for allowing the patient to remain on the ward and for down-playing the seriousness of incidents. Anger was also expressed at the administration for being slow to correct factors that might have contributed, such as shortage of staff especially male, poor physical design of wards with no ready route of escape and admitting too many dangerous patients.

A wide range of short and long term reactions to assault emerged from the 40 nurses and nursing assistants in the study by Lanza (1983). The author expressed surprise that so many reported minimal reaction or no response to the assault. Respondents' comments indicated that this was due to staff not being able to function if they thought about the assault, and accepting it as part of their job. Short-term reactions included denial of any

thoughts, preoccupation with the assault and considerations of job or professional changes. Long-term reactions included the emergence of concern about lack of administrative support. Respondents felt there should be more concern for staff rights. While feeling guilty at not pressing charges against patients, respondents believed there would be little administrative support if they did so.

In the UK, Aiken's 1984 study of incidents on a locked ward included interviews with staff (23) about their response to assault. One staff member resigned after being involved in three violent incidents in a month. Two who had been involved in incidents (2 and 3 respectively) both expressed significant discontent with their jobs because of violence. A fourth involved in six incidents reported no change in attitude to her job. Aiken commented that despite the levels of violence, only three staff expressed discontent about the job for this reason but commented that the effect of working in what he described as a stressful environment may be reflected in other ways, such as sick leave, and that this merited further study.

3.9 EDUCATION

The UK guidelines produced during the 1970s had emphasised the importance of staff training in the prevention and management of violence (Section 2.2.2 ii)). Very little research in the UK had in fact focused on staff views of training received at either pre-registration or post-registration levels. As indicated in Chapter 1 (Section 1.1.2) the lack of such research lay behind commissioning of the DHSS funded project.

3.9.1 Pre-registration training

Brailsford and Stevenson (1973) reported that their respondents thought more direction was needed in training and 72% of qualified staff thought that nurses were introduced to situations of violence without adequate preparation. The authors recommended that students needed better introduction to acute wards (Brailsford and Stevenson 1973).

A few studies had investigated the education and experiences of learners preparing for the RMN or SEN (M) qualification (Towell 1975, Powell 1982, Clinton 1985) but none focused specifically on the preparation of learners in relation to the prevention and management of violence. Two studies of general nurse learners, however, had

considered the subject. Strong (1973) surveyed student and pupil nurses' experiences of aggression, defined as verbal abuse and physical violence. during placements in general hospital wards. Wilkinson (1982) researched general nurses' apprehensions about psychiatric nursing placements, including the likelihood of violence. My DHSS funded study of learner nurses, made available to the DHSS in 1990 but published some years later, found that while most of the 41 students interviewed during their course reported that it had been an adequate preparation in understanding the causes of violence and in learning how to prevent its occurrence, the majority did not feel adequately prepared to manage violent incidents (Robinson 1999).

3.9.2 Post-registration and in-service education

Several of the authors whose studies are reviewed above drew attention to specific aspects of training needs in relation to violence. Participants in the Brailsford and Stevenson (1973) survey thought that qualified staff needed more direction in how to manage violence when persuasion fails. From studying predictors of violent incidents, Aiken (1984) concluded that staff needed training and discussion about such predictors to increase their confidence about anticipating potential assaults. Having found that unqualified staff were more likely to be victims of assault than qualified, Leopoldt *et al.* (1978) recommended that the former needed training in skills of handling potentially aggressive patients. A survey of in-service courses on violence in England and Wales showed that by the end of 1985 provision was not universal; 60% of districts had held and/or planned to hold these courses (Robinson and Barnes 1988, 1989). Those who had attended the Joint Board of Clinical Nursing Studies Course on *The care of the violent or potentially violent patient* found it useful in many respects, although some had encountered difficulties when seeking to put their new-found knowledge and skills to use in their subsequent work (Robinson and Barnes 1988, 1989).

3.10 REVIEWING RESEARCH BEFORE AND AFTER FIELDWORK

Most of the research undertaken prior to my study had taken the form of studies that aimed to identify variables associated with incidents of violence, some of which had included nurses' views about aspects of incidents. Other studies had provided information on how nurses felt about involvement in restraint and about being assaulted. A UK study by questionnaire had attempted to ascertain nurses' views on a range of

aspects of violence (Brailsford and Stevenson 1973) but none, as far as I discovered, had adopted a qualitative approach for this purpose. Considered as a whole, this research identified a range of dimensions of violence, together with details of each, that informed the design of my study of nurses' views and experiences.

Since the fieldwork was completed there has been an enormous increase in the volume of research undertaken into violence that has relevance to the role and education of nurses. I read much of this literature while undertaking the analysis of the interview data and other research activities that included the subject (Section 1.2). When I undertook my study, very little was known about nurses' views and experiences in relation to violence. Consequently I included a wide range of topics and a wide range of settings. Each topic has been researched subsequently to varying extents. A combination of the breadth of topics and the length of time since fieldwork meant it was not feasible to provide a full review of this subsequent research. Moreover, other reviews exist, some very substantial (e.g. Wright *et al.* 2002). The approach I decided to adopt was to provide an indication of the main directions that have been pursued in subsequent research that had relevance to the dimensions of my conceptual framework, illustrated with examples of specific projects. A fuller account of the approach adopted is given in Appendix 1. While recognising that there is some degree of overlap, the subject of the studies have been grouped as follows: incidents of violence (Section 3.11); staff-patient interaction (Section 3.12); involvement in managing violence (Section 3.13); effects on staff of assault (Section 3.14); accounting for aggression and violence (Section 3.15); and education and guidance (Section 3.16).

3.11 INCIDENT STUDIES (POST-1987)

In the period after fieldwork, studies of records of incidents continued. Some authors (e.g. Haller and Delouty 1988, Whittington and Wykes 1994a) drew attention to methodological problems that had limited the usefulness of earlier studies and discussed appropriate methods to be adopted. A feature of some of these subsequent studies was the attempt to identify factors antecedent to incidents that could inform staff training on the subject (e.g. Powell *et al.* 1994).

Other studies provided insights into the relationship between staffing and incidents: of particular note was one by Fineberg *et al.* (1988) that examined the relationship between violent incidents and employment of agency staff. An analysis was undertaken of 15 months' data on agency versus permanent nursing provision and violent incidents that included assaults on staff and other patients. self-harm and damage to property. Findings showed that permanent nursing provision was halved during the study period whereas agency provision almost trebled both in units and in numbers of shifts. The authors found a significant positive correlation between the number of incidents and the proportion of agency staff, confirming their clinical impression that lack of cohesion in nursing provision is reflected in patient behaviour (Fineberg *et al.* 1988). Publication of findings from the Fineberg *et al.* (1988) study was followed by much discussion of their interpretation, for example whether permanent staff left in response to the incidence of violence (Baldwin 1988). The authors refuted alternative explanations, subsequently providing information that attempts to increase the proportion of permanent staff had been successful and that the incidence of violence had decreased (James *et al.* 1988). These findings link with earlier work (Armond 1982) that suggested that lack of consistency and stability in care may result in increase in disturbed behaviour (Sections 3.3.3 and 3.3.4).

3.12 STUDIES OF STAFF-PATIENT INTERACTION

During the period prior to my study, Drinkwater (1982) advocated that research into violence should study the nurse-patient relationship and its role in the generation and prevention of violence. From the mid-1990s, attempts were made to understand better the role of staff-patient interaction in the generation of incidents, as exemplified particularly in studies undertaken by Whittington and Wykes (1994b, 1996a). Whittington and Wykes concluded an earlier study of incidents (1994a) by arguing that it was time to research why attacks take place rather than who attacks whom.

Drawing on ideas developed by Maier *et al.* (1987), Whittington and Wykes (1994b) developed a cyclical model of violence. The model proposed that staff distanced themselves from patients who were repeatedly aggressive, increasing their sense of isolation which, in turn, increased likelihood of further aggression. Whittington and Wykes (1994b) proposed that being assaulted leads to increased stress for nurses and

that feeling stressed affects their subsequent behaviour towards patients. Two types of such behaviour were identified that could generate patient anger and aggression. The first was 'confrontive' coping i.e. adopting a preventive, directive or intrusive approach to patient interaction. The second type of behaviour was avoiding patients. They reviewed work that showed how this 'social distancing' could generate aggression (Whittington and Wykes 1994b). Observing that other models of violence are linear, Whittington and Wykes (1994b) argued that these failed to understand how one assault may feed forward into subsequent interactions. While acknowledging that their model did not take into account other factors that could contribute to violence, they sought to investigate further the role of staff-patient interaction in its generation. The study was undertaken by observation of these behaviours of a sample of nursing staff (103) on 12 wards of large psychiatric teaching hospital. Findings showed some evidence of an association between interaction patterns and the incidence of violence on the ward.

In a later study, Whittington and Wykes (1996a) investigated the extent to which violence by patients was preceded by aversive interpersonal stimulation. The method adopted was to interview nurses who had been assaulted within 72 hours of incidents. In a sub sample of cases interviews were also held with patients involved and other staff who had witnessed the incident. Findings showed that in 86% of the 63 incidents investigated the assault had been immediately preceded by the assaulted nurse having delivered an aversive stimulus to the patient, such as frustration, activity demand or physical contact (Whittington and Wykes 1996a).

3.13 STAFF VIEWS ON INVOLVEMENT IN MANAGING VIOLENCE

An increasing volume of research has studied nurses' views about various aspects of their involvement in managing violence, including undertaking procedures and perceptions of responsibilities. A study in the early 1980s (DiFabio 1981) showed that nurses find involvement in restraint a highly emotional experience and one for which they receive little help in dealing with their feelings (Section 3.6). Nurses' views about their involvement in restraint and other procedures to manage violence were explored in several later studies. That nurses find restraint a difficult experience was also revealed in an interview study of six nurses in an in-patient setting in Canada by Marangos-Frost and Wells (2000). The study focused on the dilemma posed by making the decision to

restrain. Not to restrain risked harm to the patient, other patients or staff. Interviewees perceived restraint not only as an unpleasant experience but also as having staffing implications in that all patients placed in mechanical restraints had to be under constant observation. reducing staff available for other patients. The interviewees also reported a lack of support from medical staff during restraint incidents and a sense that management did not fully appreciate the difficulty of the situations they faced (Marangos-Frost and Wells 2000).

The focus of work by Kinsella (1998) was the way in which male and female psychiatric nurses perceived each other's roles in the management of violence. On the basis of semi-structured interviews with staff working in a secure unit she concluded that the care versus custody dilemma, referred to by Burrow (1991), is at times reflected in the roles expected of male and female psychiatric nurses (Kinsella 1998). Men were regarded as being more effective in dealing with aggression and security (control) whereas their female colleagues were perceived as being more concerned with the overall emotional well-being of patients (care rather than control). An earlier study had revealed that female nurses working in a secure unit had often felt undermined by their exclusion by men from involvement in managing violent incidents (Kinsella and Friel 1995). An earlier interview study by Ryan and Poster (1989) of nurses' reactions to being assaulted (details in Section 3.14) showed that although all staff were trained in preventing and managing assaultive behaviour, some male staff felt they should be more responsible than women for direct involvement with assaultive patients. Some male interviewees noted that they took the lead during restraint procedures and therefore placed themselves at higher risk of assault (Ryan and Poster 1989).

3.14 STUDIES OF EFFECTS ON STAFF OF ASSAULT

Several studies have focused on the effects on staff of being assaulted, on the length of time such effects last and on the support that may be available to staff subsequently.

In response to lack of research on nurses' reactions to being assaulted. Ryan and Poster (1989) undertook a study of 61 nurses in a US neuro-psychiatric unit identified from incident records as having been assaulted. The study focused on four sets of reactions, described as emotional. cognitive. social and bio-physiological. Each nurse completed

weekly self report questionnaires. was interviewed at weekly intervals for six weeks and completed follow-up questionnaires six months and one year later. Findings showed an overall decrease in the frequency of moderate to severe reactions in each of the four categories from weeks 1 to 6 and a higher frequency of moderate rather than severe reactions throughout the six-week period. The predominant short-term reaction was one of anger, as reported for an earlier study Conn and Lion (1983). Even in the absence of major injury, however, some assaulted nurses continued to experience moderate to severe reactions up to 6 months and one year later. All respondents thought that support services for assaulted staff should be available and in this and subsequent papers the authors recommended development of such a service (Ryan and Poster 1989, Poster and Ryan 1993 and 1994).

In the UK, Whittington and Wykes (1992) undertook research into the effects of physical assault. The aim of the study was to investigate the relationship between the level of strain experienced, as indicated by psychometric instruments, and the amount of support received. The study involved interviewing 23 psychiatric nurses and one doctor within 72 hours of being assaulted and twice more within the following two weeks. Support was assessed by a questionnaire that asked for details of: opportunities to talk about the incident; physical reassurance; encouragement to seek medical advice to go home; and provision of information about nurses' rights in relation to assault.

Findings showed that most support was provided on an informal basis and correlated positively with the amount of strain experienced. Observing that support was concentrated in the immediate post-incident period yet some people's symptoms persisted for at least two and a half weeks after the incident, Whittington and Wykes (1992) suggested there is need for more support. They also maintained that nurses should be educated about how they might feel should they become involved in a violent incident, since this might help them cope with its psychological effects.

A prospective rather than a retrospective design was adopted by Adams and Whittington (1995) for a study of the extent and nature of verbal aggression, defined as including verbal threats and the use of abusive language, directed at psychiatric nurses and the severity of psychological distress in staff experiencing such assaults. A sample of in-patient and community psychiatric nurses was studied for a ten-week period. Forms for

recording incidents of verbal aggression were left at the units involved. These were visited weekly and staff who had experienced an incident were asked to record their level of anxiety on a five point scale: those who indicated 3, 4 or 5 were asked to complete a standard scale for measure of traumatic stress within 10 days. Findings showed that in-patient staff were more likely to report incidents, whereas community staff reported significantly higher levels of anxiety. The authors suggest that the latter finding may reflect relative isolation of community staff at the time of attack and also the fact that they are less likely than in-patient staff to encounter verbal aggression. They emphasised the importance of all staff having training to deal with verbal aggression (Adams and Whittington 1995).

Existence of support for staff involved in incidents was revealed in a study of all first level mental health nurses and all qualified and trainee psychiatrists working in five National Health Service Trusts in one region of England (Nolan *et al.* 1999). All staff received a previously validated questionnaire which sought information about the type and number of incidents experienced the previous year and whether support was received after such incidents. The response rate for nurses was 45% (n=301) and findings showed that half had received support, more likely from colleagues (85%) than from line managers (46%).

3.15 ACCOUNTING FOR AGGRESSION AND VIOLENCE

Several studies have suggested that nurses respond differently to patients depending on whether they regard patients as accountable for their actions. Crichton (1997) undertook such a study with nurses and nursing assistants in a range of settings in one region (n=186). The study participants were randomly allocated by setting to watch videos of incident scenarios involving patients diagnosed as having schizophrenia or personality disorder, some with a history of violence and some without. They were then asked to complete a questionnaire that involved rating the helpfulness of various responses to the incident. The data provided a complex set of interrelationships between the variables. Patterns emerged of nurses being more likely to regard patients with personality disorder to have acted out of choice than those with schizophrenia, and nurses being more likely to advocate sanctions such as suspending some recreational facilities for the former group and to use medication for the latter.

Studies by Mercer *et al.* (1999, 2000) have revealed similar distinctions made by nurses working in special hospitals who were asked to read vignettes of case histories and then interviewed about aspects of the cases. A key finding was that patients whom the nurses regarded as 'mentally ill in the classical sense (psychotic) were rarely held to be accountable for their actions' whereas patients they regarded as psychopathic were 'discussed more cautiously with extreme behaviours signalling a propensity for evil' (Mercer *et al.* 1999, p.16). In a subsequent paper reporting a similar study, Mercer *et al.* (2000) recommended caution in generalising from these findings to other settings although thought, on the basis of their experience, that these issues feature elsewhere in the psychiatric system (Mercer *et al.* 2000, p.200).

A different approach was adopted in a recent study by Benson *et al.* (2003) in that a patient, a mental health nurse and a doctor were each asked to provide their account and understanding of two incidents in which they had been involved. The study used discourse analysis techniques to analyse the interviews. The analysis revealed the following dilemmas: whether the behaviour was perceived as 'bad' or 'mad'; whether it was predictable or unpredictable; and whether it had resulted from mental illness or personality disorder. Each of the interviewees exhibited a central concern to attribute blame for the incident to one of the other people involved.

3.16 STUDIES OF EDUCATION AND GUIDANCE

The period prior to my study had seen very little research on the pre- or post-registration education of psychiatric nurses and none that focused specifically on training in relation to violence. The importance of training has been advocated in all the recent guidelines on violence (Section 2.10 ii)) and there are an increasing number of studies on the subject. Some have investigated the availability and content of training in the management of violence (e.g. UKCC 2002a). Other have investigated specific sessions for students (e.g. Wondrak and Dolan 1992, Beech 1999) and for qualified staff (e.g. Whittington and Wykes 1996b).

In response to a study showing that student nurses may experience verbal abuse (HSAC 1987), Wondrak and Dolan (1992) undertook a workshop evaluation. In this study,

psychiatric nursing students were rated on their ability to deal with verbal abuse as portrayed in a simulated situation. Half then attended a workshop on dealing with verbal abuse, then all were reassessed. The authors reported a significant change in the group that had attended the workshop in terms of both practical techniques and procedures to deal with the situation but also in their feelings about it. Beech (1999) included mental health students in a study of students' views of a new three-day unit of instruction delivered during the common foundation programme of the nurse diploma. The course included a mixture of theoretical and practical sessions on topics such as breakaway skills. The majority of students described the course as being relevant and/or useful.

Whittington and Wykes (1996b) attempted to assess the effect on the incidence of violence of staff attending a study day that focused on the cyclical model of violence that these two authors had developed (Section 3.12). The incidence of violence on wards from which staff had attended the study day was compared with the incidence on wards where staff had not done so. The comparison was for the 28-day periods immediately before and after course attendance. The findings showed that the rate of assault on the wards where staff had attended the course was 31% lower than on the wards were staff had not done so. The effect was increased for those wards that had sent a majority of staff on the course (Whittington and Wykes 1996b). The authors did not comment, however, on how long-lasting such an effect might be.

3.17 CONCLUSION

The second part of Chapter 2 (Sections 2.7 to 2.11) demonstrated how violence, particularly in relation to nursing staff, has continued to be a matter of concern in mental health services. The second part of the current chapter (Sections 3.11 to 3.16) provided some indication of the diverse range of research that seeks to address this problem. The first part of this chapter (Sections 3.1 to 3.9) reviewed the research that, together with policy developments reviewed in Sections 2.1 to 2.6, contributed to the development of the conceptual framework for my study of nurses' views and experiences in relation to violence. The design of the study follows in Chapter 4.

CHAPTER 4: RESEARCH DESIGN AND METHODS

Decisions about research design, methods of data collection and initial decisions about methods of data analysis were taken in 1985 and 1986 in the context of current debates about the appropriateness of different paradigms for studying the social world and the link, or otherwise, between these positions and particular methods. An exposition of relevant aspects of debates about epistemology, theory and method is provided in Section 4.1 and the overall choice of design for this study follows in Section 4.2. Section 4.3 discusses initial developmental work and the account then turns to preliminary decisions about: location of study (Section 4.4); choosing methods of data collection (Section 4.5); and initial analysis strategies (Section 4.6).

4.1 DEBATES ABOUT PARADIGMS, METHODS AND THEORY

Social research has long witnessed complex debates about the explanations of social action, appropriate methods with which to research social life and the respective roles of theory generation and verification. Some of the key aspects of these debates that informed decisions about the design of this study are described briefly below.

4.1.1 Theories of social action

At the time when I first formulated my study plan, debates about explanations of social action tended to focus predominantly on distinctions between schools of thought which emphasise social structure and those which emphasise individual action and its meaning. An introductory textbook like Haralambos (1985) described the former as schools of thought which maintained that people's behaviour was shaped primarily by the system; thus for structural functionalists, behaviour was largely directed by the norms and values of the social system, for Marxists it was ultimately determined by the economic infrastructure. These views were opposed by those who believed that social action was not best explained as a response to the needs and constraints of social systems but rather that it was constructed at the individual level through a process of interpretation and interaction. According to Silverman (1985), such theorists, including interactionists, phenomenologists and ethnomethodologists, maintained that appealing to social structure as an explanation for action reified social processes which could only occur at a face-to-face level. The main criticism levelled against these approaches was that they

failed 'to help locate the scenes we see in wider institutions or structures which we know help to determine them' (Davies 1982. p.41).

While the above positions were not as opposed as sometimes portrayed (Silverman 1985), they nonetheless constituted very different approaches to the explanation of social action. Subsequent developments moved in a direction which Davies (1982, p.36) described as concerning 'the fundamental issue of how social structure acts upon people and how they act as agents upon it'. Theoretical development of this kind includes both Bhaskar's (1975) realist perspective, summarised by Silverman (1985) as one which recognises the role of meaning in social life without accepting that this dissolves the constraining power of social structures and Giddens' (1979) concept of structuration which, as Davies (1982) commented, aims to show how the individual and the social structure are linked.

4.1.2 Research paradigms

Silverman (1985) observed that much empirical research on social life taking place at the time was not explicitly linked to one particular theoretical scheme or another. Some research drew on concepts from both kinds of theories, those concerned primarily with structure and those concerned primarily with meaning, whereas other research was not concerned with theory at all. Earlier Glaser and Strauss (1967) had maintained that much qualitative work, such as that undertaken by the Chicago School of sociology, had produced very little theory. Debates amongst those involved in research had focused mainly on respective strengths and weaknesses of quantitative and qualitative methods for researching particular topics and, as Bryman (1984) observed in reviewing this particular history, discussions tended to operate at the level of technical adequacy. By the 1970s, however, the debate had changed in that broader philosophical issues intruded into debates about research methods (Bryman 1984).

The two main epistemological positions, or paradigms, concerning the study of the social world were, by this time, usually referred to as positivism and interpretivism. Discussions about differences between these two paradigms focused on their central beliefs about the nature of society, the role of theory, the research methods with which they were usually associated and the relative emphasis placed on reliability and validity. Many commentators have observed that these differences are not as rigid as often

depicted (e.g. Haralambos 1985, Silverman 1985) but that they served to illustrate the essential features of the two positions.

Positivism, the view as Davies (1982, p.42) observed, that there is a 'world out there that can be described, measured, generalised about and even predicted' was, and is often, regarded as the paradigm which typifies the approach adopted by the natural sciences. While there has been much debate about details of the approach actually adopted, its key elements are held to be that behaviour of matter may be described in law-like terms reacting in predictable ways to external stimuli and that these reactions can be shown experimentally. The natural sciences seek to discover these laws through systematic observation and experiment; the results of these observations are regarded as objective facts, the accuracy of which can be checked through replication by others of the observations and experiments under the same conditions. Through this process, causal relationships between factors or variables can be established and a theory can then be constructed to explain the observed behaviour and be refined or refuted through further work.

Social science researchers categorised as positivist started from assumptions that behaviour in the social world, like that in the natural world, was a reaction to external forces, conformed to discoverable laws and could be explained in terms of cause and effect relationships. Consequently, they maintained, methods of the natural sciences were appropriate for studying social life. They argued that only behaviour that could be directly observed and measured constituted acceptable data, precluding reliance upon meanings and feelings. The study of behaviour should be based on objective measurement with an emphasis on acts which could be observed and quantified. Statements of cause and effect might be inferred on the basis of these observations and theories devised to explain them that could be further tested and refined through subsequent empirical work. As Walker (1985a) observed, positivism is concerned with formulating and empirically testing explanatory or predictive theories that tend toward deductively, axiomatically structured systems of empirically verifiable statements. This leads to an emphasis on quantitative methods, on rigour, objectivity, measurement, and on reliability of instruments and methods of analysis. A tenet of the positivist position is that qualitative methods can only have an exploratory function; for example, as a

means of further defining a concept before it is operationalised for inclusion in a closed item questionnaire.

Proponents of interpretivist paradigms maintain that differences between the natural and social worlds rule out the possibility of using techniques of the natural sciences to study social phenomena. They argued that human beings are not analogous to particles acted on by exogenous forces (Walker 1985a); in contrast they are persons who construct the meaning and significance of their realities (Jones 1985a). If social reality is to some extent defined and constituted by its participants, then researchers' prior definitions of concepts and hypotheses may impose meanings on social relations that fail to pay proper attention to participants' meanings (Silverman 1985). In order to understand why people act as they do, we need to understand the meaning and significance that they give to their actions (Jones 1985a).

In reviewing debates about different approaches to studying social life, Walker (1985a) observed that dissatisfaction with what was often termed a positivistic social science focused on concern with reliability at the expense of validity. Thus, theoretical concepts were often insufficiently precise to suggest an appropriate measurement tool, and the control and simplification necessary for measurement and replication meant that the fundamental complexity of certain social phenomena was ignored. Rather, understanding should be acquired through engaging with the subject and interpreting what is going on from within the social context in which these events occur, and such engagement was facilitated by qualitative methods of participant observation and in-depth interviewing (Walker 1985a).

As to theory, interpretivists sought to induce theory from data rather than to use data to verify or refute an existing theory. A major influence in this approach to developing theory was the views of Glaser and Strauss as propounded in their book *The discovery of grounded theory* (1967). Silverman suggests that Glaser and Strauss saw their position as critical of Merton's 'middle range theories' since these were 'tied to the logic of verification and based on hypothesis testing [and] overlooked how research might generate theory and was inappropriate to most qualitative work' (Silverman 1985. p.8). Glaser and Strauss (1967) argued that sociologists should concentrate on generating theory inductively from the process of social research itself: rather than being logically

deduced from a priori assumptions, it should be grounded in the experiences of those being studied.

4.1.3 The process of generating theory

Although this study did not adopt the purely inductive approach to theory generation advocated by Glaser and Strauss, it was influenced by some aspects of their work and so their key tenets are outlined here. The process of generating theory that they advocated had several stages. Researchers should start with a hunch, a particular perspective, or a problem to guide data collection rather than with a specific theory to test. After a period of time, a process usually referred to as the constant comparative method should be employed. As described by Glaser and Strauss (1967), this entails taking each segment of data in turn, noting its relevance to one or more emerging categories and then comparing it with other segments of data similarly categorised. This process develops the category's properties and enables the range and variation of any given category to be mapped in the data and such patterns plotted in relation to other categories (Hammersley and Atkinson 1983). The data is thus examined without theoretical preconceptions, in order to develop a set of substantive categories to represent what is going on in the area being studied.

These categories provide the raw material for developing theoretical categories at a higher level of abstraction. Walker (1985b) described this process of development as one of identifying underlying uniformities in the original set of categories, or their properties, to produce a reduced set of higher-level concepts. The next stage was identifying relationships between theoretical categories, the accumulation of which formed an integrated theoretical framework that was the core of the emerging theory. This emerging theory guided further data collection and analysis, with a point of 'theoretical saturation' being reached when additional data ceased to contribute to further understanding of the categories and their properties. Generating theory in this way depended on data collection, coding and analysis being undertaken concurrently, since each part of the process informed the others. The ongoing analysis of data leads to the emergence of new ideas, categories, hypotheses and theoretical questions that in turn specify directions for further study.

For Glaser and Strauss (1967) the aim of research was to produce a systematic account of the relationship between a limited number of variables, often confined to a particular setting. They referred to this as a substantive theory. They maintained that grounding theory in the lives and experiences of those being studied meant it fitted better with the empirical situation than did existing, logically deduced, theories. They also sought to move beyond substantive theory to formal theory, describing the latter as theory that explained a process that arose in a range of contexts. Although Glaser and Strauss's approach had enormous appeal (Jones 1985b) it was not without its critics. Bulmer (1979), for example, queried whether researchers are genuinely capable of suspending their awareness of relevant theories and concepts until a relatively late stage in the process and Hammersley and Atkinson (1983, p.22) contended that Glaser and Strauss seriously underrated the importance of testing theory 'sometimes implying that 'grounded theory' once developed is more or less beyond doubt'.

4.1.4 Theoretical dimensions to research

As already noted, it had been observed that much research on social life had not been concerned with theory at all (Glaser and Strauss 1967, Silverman 1985). However, these authors and others (e.g. Bulmer 1977) rejected the view that theoretical considerations were not important and that sound method was sufficient. While acknowledging the importance of a theoretical component to research, Hammersley and Atkinson (1983) nevertheless identified a series of what they called 'way-stations' along the road of theoretical development observing that researchers can make useful additions to knowledge at each:

i) descriptive accounts that do not attempt to derive any general theoretical lesson, but do provide knowledge about hitherto unknown ways of life or beliefs of a particular group of actors. Even when the purpose of research is primarily descriptive or exploratory, the social world does not speak for itself (Silverman 1985, Jones 1985b). The very process of deciding 'what is', and what is relevant and significant in 'what is', involves selective interpretation and conceptualisation' (Jones 1985b, p.57);

ii) developing more general categories, such as particular kinds of interactional strategy, and under which features of the phenomenon start to be collected together;

iii) developing a typology of perspectives or strategies which represent subtypes of some more general strategy: and

iv) integrating a range of analytic categories into a model of social processes: this is the stage of developing a substantive theory, as advocated by Glaser and Strauss (1967).

4.1.5 Position adopted for this study

The foregoing is a considerable simplification of complex debates and, as some of the authors from whom it was drawn have commented, there is much overlap between the various positions outlined. Systems theories, for example, are not solely concerned with structure at the expense of meaning and while interactionism has a primarily interpretivist approach to method, it also has positivist elements (Silverman 1985). In similar vein, Davies (1982) comments that there are no simple divides between quantitative and qualitative data and objective and subjective analysis. Much qualitative work sets out to do no more than treat meaning objectively and in an inescapably positivistic manner. Adopting a structured questionnaire for a study does not imply that one is a positivist in the sense of having no concern with participants' interpretation of events (Marsh 1982). Setting out polarities, however, is a means of emphasising differences and extremes that exist. Identifying key features of the various positions was an important stage in deciding how the subject of my study might best be approached.

4.2 DEFINING THE PROBLEM AND CHOOSING A DESIGN

4.2.1 Defining the problem

As several authors observed, there are no immutable rules for deciding the degree of precision with which a research problem should be formulated when starting a study or how it may be reformulated during data collection and analysis (Hammersley and Atkinson 1983, Walker 1985a, Silverman 1985). During a study, through a process known as progressive focusing, researchers may discover what their research is really about and this may be 'about something quite remote from initial foreshadowed problems' (Hammersley and Atkinson 1983 p.175). A distinction has been made between problems that derive from practical or policy concerns and those with a more generic cast (Lofland 1976, cited in Hammersley and Atkinson 1983). As indicated in Section 1.1.1, this study addressed a problem that derived from the former: namely that

insufficient was known about nurses' views and experiences of violence to inform policy development. As the study progressed, the problem pertaining to policy became more sharply focused.

4.2.2 Choice of research design

The design was that of a case study using primarily qualitative methods. Yin, a key proponent of the case study at the time, describes its distinguishing characteristic as an attempt to examine a contemporary phenomenon in its real life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin 1984). This approach seemed appropriate for this study since it was likely that nurses' views and experiences in relation to violence would be influenced by the services in which they worked, as well as by their previous educational and practical experiences. I decided, therefore, to undertake the research in one institution rather than in several. Case studies are also indicated when there is a need to understand complex social phenomena and where the primary questions concern how processes work out in a particular case or limited number of cases. The literature review (Chapters 2 and 3) had indicated that violence in psychiatric settings had many dimensions and these, and the possible interrelationships between them, are shown in the conceptual framework formulated for the study (Section 4.3.2).

The decision to undertake a case study was closely linked to the decision to use qualitative methods. Although it is important not to confuse case study with qualitative methods, these are usually employed rather than quantitative methods (Yin 1984). The literature review indicated that qualitative would be more appropriate than quantitative methods, given the nature of the research problem with which this study was concerned. Firstly, qualitative methods are often advocated for subjects about which little is known and which thus do not lend themselves to investigation by a structured instrument (Walker 1985a). Although much had been written about violence in psychiatric services, little research had focused on experiences and views of nursing staff. A second reason was their obvious appeal when the subject of investigation is sensitive and in-depth exploration is indicated (Walker 1985a). Certainly there was an indication that nurses' views had been neglected and that nurses had been censured for actions perceived as inappropriate (Martin 1984). Broaching the subject was likely to involve entry into sensitive, even highly emotionally charged, areas. A third reason was the

apparent complexity of the subject, requiring in-depth exploration of interrelationships between its various dimensions (Walker 1985a). The literature review suggested a series of possible interrelationships between the various dimensions of violence and between these and the context in which they occurred, again indicating qualitative methods and a case study as appropriate.

As Walker (1985a) observed, it is important to be clear about the distinction between the philosophical traditions that have informed the development of qualitative methods and the methods themselves. The characteristics of the methods are very similar whatever the philosophical context in which they are deployed; what differ are the significance attached to these characteristics and the status accorded to the information that they produce (Section 4.1.2). The position taken for this study was that qualitative methods were not merely exploratory, of use only prior to quantitative modes, but were sufficient in investigating the subject.

Advocates of case studies have stressed their strength in terms of validity, arguing that while measurement studies produce technically reliable data, these are difficult to interpret and are weak on validity (Walker 1982). A common criticism of case studies, however, is that their reliability usually depends on a single observer whose work is rarely checked. It is important, therefore, that researchers provide details of the ways in which their work is undertaken in order that others can assess the reliability of their findings. In the literature of the time, there was discussion about the generalisability of findings from case studies and two strands of thinking prevailed.

The first strand, common in education research using case studies, was that of naturalistic generalisation (Stake 1978). In selecting a case-study site, researchers are not claiming that it is representative, rather that it illuminates critical or significant elements of the situation. It was incumbent upon researchers to provide a careful description of events and to connect the particularities of the case to a wider context. If readers felt the account to ring true, and were able to recognise aspects of their situation in what was being described, they extrapolated from the insights of an account to their own situation: external validation was thus the responsibility of users rather than creators of research (Walker 1980). Theoretical considerations in individual case studies were not accorded a high priority: rather the view prevailed that theoretical

progress would only emerge gradually as a residual accumulation from the collection of case studies (Walker 1982). The second strand of thinking placed greater emphasis on theoretical models as the basis for inference to other situations. Silverman (1985) drew together arguments that advocated a position in which extrapolation from case studies to like situations was based on the cogency of theoretical reasoning rather than the typicality or representativeness of the case. My initial thoughts were influenced by both positions in that I intended to provide detailed accounts of nurses' views and experiences but also move beyond Hammersley and Atkinson's first stage of theoretical development (Section 4.1.4).

4.2.3 Pre-structuring prior to fieldwork

A key question of the period was how much shape a qualitative design should have prior to fieldwork and how much pre-structuring of sampling and instruments should take place. Miles and Huberman (1984) usefully summarised arguments for and against what they described as prior focusing and bounding of a study. Those advocating that pre-structuring should be minimal argued that social realities are so complex that to go into the field with a predetermined conceptual framework and research questions would be to risk missing the key questions which could only emerge empirically. Moreover, only after immersion in the field would indications emerge about the settings and actors to concentrate upon, and about how to focus the content of data collection instruments. To pre-structure would be to risk missing key features.

In Miles and Huberman's view, a loosely structured, highly inductive design is appropriate in unfamiliar cultures and when phenomena are complex and little understood. In more familiar situations, however, when something is known about the phenomena, such a design is wasteful of time since much would be spent ascertaining what was already known. A loosely structured design may be appropriate when researchers have plenty of time. If time and budget are limited, however, as is likely with contracted, policy oriented research, some degree of pre-structuring will ensure more effective use of both. If some pre-structuring is not undertaken, researchers are likely to have more data than they will have time to analyse (Miles and Huberman 1984).

Some degree of pre-structuring seemed to be appropriate for my study. The literature review and discussions with policy personnel provided sufficient information to develop an initial conceptual framework and associated questions. Moreover, time was not unlimited since opportunities for data collection would occur during fieldwork for a commissioned project with predetermined funds and timescales.

4.3 INITIAL DEVELOPMENTAL WORK

4.3.1 Developmental approaches

Following advice of authors such as Hammersley and Atkinson (1983) and Miles and Huberman (1984), three interrelated activities were undertaken prior to starting fieldwork. The first was exploring the main components or dimensions of the problem and possible relationships between them; Miles and Huberman (1984) refer to this as developing a conceptual framework. The second was formulating questions for each dimension since it is through these that an answer can be given to the foreshadowed problem at one of the levels of theoretical complexity, identified by Hammersley and Atkinson (1983) and discussed in Section 4.1.4 of this chapter. The third activity was considering appropriate ways to draw on and develop theoretical perspectives.

In qualitative research the conceptual framework may be revised during fieldwork, the questions may be reformulated and refined and other questions may emerge. Adopting such a developmental approach to theory has also been advocated; thus while researchers should draw on existing theoretical perspectives to inform and focus the work, they should also be open to new theoretical perspectives emerging as relevant (Hammersley and Atkinson 1983, Miles and Huberman 1984, Walker 1985a, Silverman 1985, Jones 1985b).

In the early stages of a study, development of the conceptual framework and questions can draw on empirical work and theorising of others (Hammersley and Atkinson 1983, Miles and Huberman 1984, Walker 1985a). During data collection researchers are continually 'making choices, based on research interests and prior theories about which data they want to pick up and explore further' Jones (1985a, p.47). Similarly during data analysis, while investigating relationships between categories, emerging ideas might have connections with existing theory (Jones 1985b). This approach, which

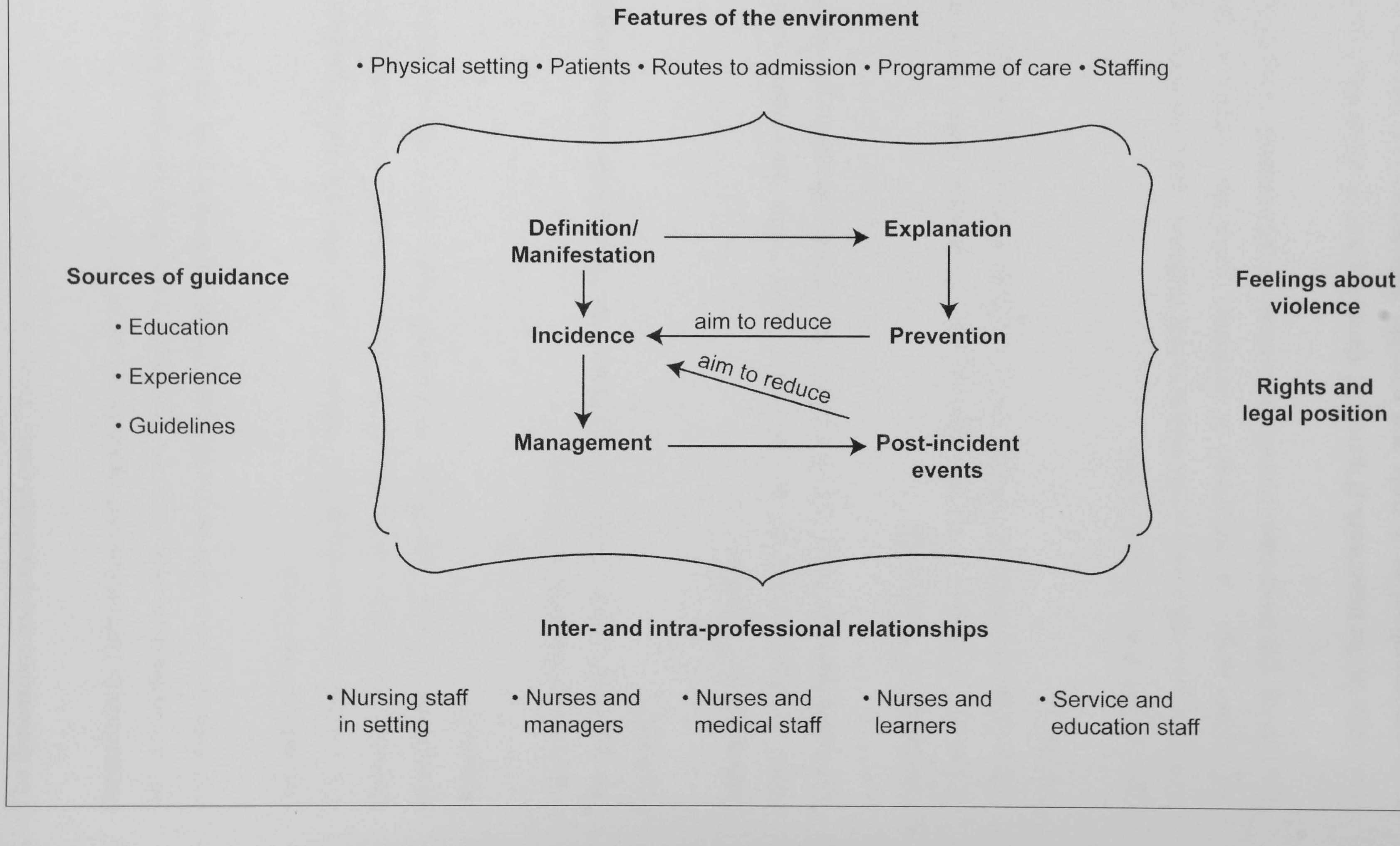
contrasted with Glaser and Strauss's purely inductivist approach to theory generation, was the one I proposed to adopt; theoretical perspectives existed that I thought could contribute to understanding the problem from the outset and I thought it likely that others might be relevant to interpreting findings.

4.3.2 Initial conceptual framework

While there are no immutable rules as to whether developing the conceptual framework should precede or follow formulating questions (Miles and Huberman 1984), I found that the two activities occurred concurrently since, as dimensions were identified, associated questions sprang to mind. Developing the conceptual framework included bringing together numerous discrete events and behaviours to form a dimension (termed a 'bin' by Miles and Huberman 1984) to which an overarching label was given. The framework was kept to one page following advice that this helps researchers find the 'bins' that hold discrete phenomena, map possible relationships, and work with all the information at once (Miles and Huberman 1984).

For this study, eleven separate dimensions were identified from the policy and research literature reviewed in Chapters 2 and 3 and an initial conceptual framework was formulated which included relationships between them (Figure 4.1). Each dimension provided the basis for the formulation of research questions. Advice in formulating questions included having no more than two dozen, since more would tend to over-fragment data and make it harder to perceive links across the framework (Miles and Huberman 1984). Moreover, keeping questions focused increases the likelihood that satisfactory answers will be provided (Walker 1985, Silverman 1985). Formulating questions enables researchers to move from the conceptual framework to considerations about instruments and sampling; the questions are in effect a way of operationalising the conceptual framework (Miles and Huberman 1984). In this study they formed the basis for developing a topic guide for depth interviews (Section 4.5.2).

Figure 4.1: Conceptual Framework



The dimensions and associated questions are described below.

Dimension 1: Definitions and manifestation of violence

The questions associated with this dimension were: 'how do nurses define aggression and violence?'; and 'how are these manifest in the settings in which they work?'

Dimension 2: Incidence

The question associated with this dimension was: 'what are nurses' perceptions of the frequency of incidents in the settings in which they work?' I recognised that differing perceptions of what constitutes an incident might affect nurses' reports of their frequency.

Dimension 3: Explaining violence

The question associated with this dimension was: 'what explanations do nurses offer for violence?'

Dimension 4: Prevention

Questions associated with this dimension were: 'what are nurses' experiences of preventing violence?' and 'what are their views on how it should be prevented?'

Dimension 5: Management

Questions associated with the management dimension were 'what are nurses' experiences of managing violence?' and 'what are their views on how it should be managed?'

Dimension 6: Post incident events

Questions associated with post-incident events included: 'what are nurses' experiences and views about the recording of incidents: about the holding of post-incident discussions; and about support available to nurses in the aftermath of incidents?'

The centre of the framework [Figure 4.1] shows the way in which these six dimensions were conceptualised as a cycle and possible interrelationships between them. The literature review suggested that these six dimensions could be influenced by the context in which they occurred and five dimensions of this context were identified, as follows:

Dimension 7: Features of the environment

This dimension was concerned with nurses' perceptions of: the ways in which the physical environment was related to violence; the adequacy of resources of staff. facilities and equipment; and the appropriateness of patients for the settings in which they worked.

Dimension 8: Sources of guidance

This dimension focused on the sources of guidance on which nurses could draw in relation to violence. Associated questions concerned their experiences and views about their first level training, about subsequent opportunities for education on the subject, and about the availability and usefulness of guidelines on violence. Perceptions to be explored included links between adequacy of preparation (their own and that of others involved) and approaches to preventing and managing violence.

Dimension 9. Feelings about violence

Associated questions on this dimension were: 'what are nurses' feelings about encountering violence?' and 'how do they feel towards patients involved in incidents?'

Dimension 10: Balancing patients' and nurses' rights and legal position of the nurse

Questions associated with this dimension included: 'what are nurses' views about the balance of patients' rights with their own?'; and 'how do they perceive the clarity or otherwise of their legal position when involved in an incident?'.

Dimension 11: Inter- and intra-professional relationships

This dimension focused on the ranges of inter- and intra-professional relationships within which nurses worked and the ways in which these might affect their experiences and views of violence. Questions associated with this dimension focused on: the views and support of other ward/community staff; the role of nurse managers / health authority personnel in making resources available; the attitudes of managers towards staff involved in incidents; and the role of medical staff in decision-making about admission and subsequent treatment of patients.

In a policy oriented study, developing research questions may involve making more explicit the strategies that might lead to a likelihood that some desired aspect of policy will be achieved (Miles and Huberman 1984). In this study, one of the underlying premises was the desirability of reducing incidents (Section 1.1.4). Defining the ideology behind policy development orientates the formulation of research questions for each dimension, for example in this study the question: how do nurses think violence should be prevented?

4.3.3 Perspectives from the theory of symbolic interactionism

In the early stages of the study, many of the key concepts in the theory of symbolic interactionism appeared relevant to interactions between nurses and patients in relation to violence. As observed by Davies (1982), symbolic interactionism originated from the work of American philosophers of the pragmatist tradition, such as James (1950), Dewey (1925), and particularly G.H. Mead (1934). The theory was further developed within the social sciences, particularly by Herbert Blumer (1962).

The theory is concerned with understanding the process of interaction between individuals and is usually regarded as a phenomenological perspective because of the emphasis that it places on actors' views and interpretations of social reality (Haralambos 1985). Mead posited that people act on the basis of meanings that they attach to objects and events rather than in reaction to externally imposed forces. These meanings are imposed through symbols that both define an event and indicate a response to it. Interactionism begins from the assumption that action is meaningful to those involved in it. Meanings are derived from actors' definitions of situations, from their concepts of self, and from processes of interpreting and responding to actions of others. The way in which actors define situations, i.e. the contexts in which interaction takes place, represents their social reality and they structure actions in terms of this. Actions also depend in part on self-concept, in Mead's terms referring to individuals' pictures of themselves which they develop through others' reactions to them.

Interactionist theory also posits that meanings are not fixed entities but, rather, are created, developed, modified and changed within the actual process of interaction i.e. they emerge from a process of negotiation. Mead identified a process usually referred to as 'role-taking', namely that actors put themselves in the position of those with whom

they are interacting in order to interpret their intentions. On the basis of this interpretation they then structure their own response. which others in turn will interpret and to which they will make further response. Human interaction can be seen as a continuous process of interpretation with each actor taking the role of the other, the meanings which guide action arising in context via a series of complex interpretive procedures. Methods for understanding human interaction must enable researchers to investigate the ways in which individuals perceive the context in which their actions take place and to analyse ways in which they interpret the language, gestures and appearance of others and develop their concept of themselves. Qualitative forms of observation and interviewing are the methods usually deployed to these ends.

Although symbolic interactionism was an appropriate perspective in conceiving questions and understanding processes concerning nurses` views and experiences of violence, critiques of it were also relevant, as discussed by, for example, Haralambos (1985). Firstly, it has been criticised for examining human interaction in a vacuum and ignoring influences that historical events and wider social frameworks may have on interactions. The literature review had indicated that such events and frameworks might influence action and were thus included as dimensions in the conceptual framework (Section 4.3.2). Secondly, symbolic interactionism has been criticised as going too far in trying to counteract theories that saw action as determined by wider social forces. In stressing flexibility and freedom of human action, interactionists have played down constraints on action and have failed to give an account of social structure. They have also neglected how standardised normative behaviour comes about, and why people chose to act in one particular way rather than another. This study did include perceptions of social structural constraints, such as the adequacy of nurses' education, which might influence the nature of interactions.

4.4 LOCATION OF STUDY

Having decided to undertake a case study (Section 4.2.2), I concluded that the study site should be a health district. This was driven partly by the DHSS funded project concerning learners' experiences and views since nurse training schools at the time were usually district-based and drew primarily on experience available within its confines. For my study of staff experiences and views, a health district would encompass a range

of psychiatric services. From a practical standpoint, districts were the basic administrative units in the NHS at the time and negotiations for access to learners and staff would have to be conducted through a district-based management hierarchy. From the perspective of generalisability of findings (Section 4.2.2), in fields where individual variation within a class seems to be limited, case studies are widely accepted as a valid basis for generalisation (e.g. Walker 1982). For this study, there seemed to be no reason why experiences and views of psychiatric nursing staff and learners in one health district should be totally different from those in others.

Criteria for selecting a health district encompassed both theoretical and pragmatic considerations. Whatever stage of development the research problem has reached prior to data collection, it is likely to provide indication of sites that might usefully illuminate the problem (Hammersley and Atkinson 1983). The site chosen should not only give researchers opportunities to observe the topic but should also be one which will maximise intensity of the phenomenon and the frequency with which it occurs (Morse and Field 1985). The literature review for this study had indicated that incidents occurred in a range of services although their frequency and nature differed (Section 3.2.1). Consequently a site was required that included the full range of services. Time and costs involved in travelling are often important pragmatic considerations in narrowing down the selection (Hammersley and Atkinson 1983).

Prior to fieldwork, consideration was given to sampling within the case study site, following Miles and Huberman's (1984) advice that if some initial decisions are not made there is a danger of collecting more information than can be analysed in the time available. Moreover, given that practical matters such as time available, variable access to people and events and inevitable logistical problems all constrain the amount of data that can be collected, it is important to focus on data deemed to be central to the problem. Sampling in a qualitative study is described as being theoretical (Glaser and Strauss 1967, Walker 1985a) or purposive (Morton-Williams 1985) rather than representative. The settings, people and events selected are those which researchers think are likely to be relevant to, and offer different perspectives on, the research problem. I recognised that it would not be feasible to include all settings for each service. While I proposed to include all grades of nursing staff on the grounds that experiences and views might differ in ways that illuminated the subject, I recognised

that some selection would be required. An orientation period in the selected site was proposed during which decisions about sampling could be made (Section 5.3.1). I considered whether to include the perspectives of patients and other healthcare staff but, while recognising their importance, concluded that to do so would require additional resources and my priority was exploring nurses' perspectives. Moreover, I recognised that permission to interview patients might be much more difficult to obtain than permission to interview nursing staff, that patients might be unwilling to be interviewed and that such interviews might require different skills from those for interviewing staff.

4.5 CHOICE OF METHODS FOR DATA COLLECTION

4.5.1 Choosing interviews

If researchers have a fairly clear idea of the kind of information they are seeking, there is no reason not to plan in advance how it might best be obtained (Miles and Huberman 1984). As noted in Section 4.2.3, my approach was one of doing some pre-structuring prior to fieldwork and so a choice of method was made before this commenced.

The aim of investigating nurses' experiences and views about the dimensions of the conceptual framework indicated that depth interviews would be appropriate. As Jones (1985a, p.46) maintained:

> *'To understand why persons act as they do we need to understand the meaning and significance which they give to their actions. However, in order to understand other people's constructions of reality it would be better to do so through asking them (rather than assume we can find out by observing their overt behaviour) ...'*

Drawing on Silverman (1985) I thought through what I would regard the interview data as representing in the context of the epistemological debates referred to in Section 4.1. Silverman defines his own position as realist in that he seeks to incorporate what he regards as the valuable aspects of the internalist/externalist dichotomy, namely that interviews are either situated encounters where what is said only makes sense in context or they are simply research instruments designed to get at facts which are context-free. The internalist aspect of the interactionist position is valuable in that interview responses can be treated as displays of perspectives and moral forms; thus, as Hammersley and Atkinson argue (1983), interviews are evidence of perspectives of particular groups. At the same time, however, interviews display cultural particulars

that, in turn, express and reveal social structures and in that sense they are displays of reality. This position seemed to fit with the questions associated with the dimensions of the conceptual framework (Section 4.3.2) in that they were concerned both with nurses' interactions and with their perspectives on the factors that facilitated or constrained these interactions.

4.5.2 Designing interview guides

Various terms have been used to describe the types of interviews used in qualitative research in order to distinguish them from those which are employed in quantitative research and which usually comprise closed questions to be asked of all respondents and in the same order. These terms have included: open ended; depth; in-depth; semi-structured; and unstructured. In commenting on terminology, Jones (1985a) observed that there is no such thing as a totally unstructured interview and the term is overused and used carelessly. Her preference, and the one which I adopted, is for depth interview, a term defined by Walker (1985a, p.4) as 'a conversation in which the researcher encourages the informant to relate, in their own terms, experiences and attitudes that are relevant to the research problem'.

In discussing structure in qualitative interviews, Miles and Huberman (1984) maintained that if instruments are not focused, much superfluous information will be collected that is likely to compromise the power and efficiency of analysis. Moreover, some degree of structure is needed when researchers intend comparing across units within the site as indeed was proposed for this study (Section 4.4). Furthermore, some structure should be imposed during the interview in that researchers see patterns emerging in the data and use these to make decisions about directions to explore further (Walker 1985a, Jones 1985a). Lack of structure has also been identified as a problem for interviewees. Open-ended interviewing is a form of control in that it is difficult for interviewees to know what is relevant (Hammersley and Atkinson 1983). Moreover, if interviewees are encouraged to ramble and are not given an idea of the researcher's interests, they are more likely to feel 'constrained than unconstrained in their answers by the need to put energy into guessing what these (the researchers' intentions) are' Jones (1985a, p.48).

Notwithstanding the foregoing, writers on qualitative interviewing have stressed those aspects of lack of structure that distinguish the depth interview from its structured

quantitative counterpart. Thus, it is recommended that researchers have a topic guide and then devise questions to introduce the topic in a manner and order appropriate to each interviewee (Morton-Williams 1985. Miles and Huberman 1984. Walker 1985a). Moreover, researchers should encourage interviewees to raise issues of importance to them. Jones (1985a, p.46) summarises the essence of what the qualitative interview should avoid as:

> *'predict[ing] in detail, what is relevant and meaningful to their respondents about the research topic [since] in doing this they have significantly pre-structured the direction of the enquiry within their own frame of reference in ways that give little time and space for their respondents to elaborate their own'.*

On the basis of the research questions associated with the dimensions of the conceptual framework (Section 4.3.2) I designed an initial topic guide for staff working in institutional and community settings and one for nurse managers. The guide was modified during the course of an orientation period in the fieldwork site to include topics that emerged as relevant to particular groups of staff but not to others (Section 5.3.4).

From the outset, strategies to enhance the validity and reliability of the data were considered. Jones (1985a) observed that the interview is so integral to social research that its complexity as a social interaction can sometimes be forgotten or obscured and that a central part of the framework the researcher brings to preparing for, and analysing, interviews must be an awareness of factors which affect the data their interviewees provide. For my study, this included awareness of issues entailed in interviewing elites (senior nursing managers in this instance), and awareness of the impact, on interviewer and interviewee, of talking about a potentially distressing subject. Awareness of site-specific factors that might affect provision of data was gained during negotiations for access to the selected site (Section 5.2.3) and an orientation period (Section 5.3.3).

As others have advocated (Burgess 1984, Morton-Williams 1985) using a tape recorder ensures an accurate and comprehensive record of the interview. Such a record is much less easy to achieve by taking notes while also concentrating on what the interviewee is saying. My preference, therefore, was to record the interviews. Moreover, recording rather than note-taking facilitates the maintenance of eye contact and the observation of

non-verbal cues such as expressions of unease that indicate a topic might usefully be further pursued.

4.5.3 Using other methods

Consideration was given to using observation and document analysis as well as interviewing in the context of debates about what was referred to as triangulation: namely that phenomena are better understood through recourse to more than one method. As summarised by Silverman (1985), debates about between-method triangulation had focused on whether this should be regarded as a means whereby one method could be cross checked against another to produce a single picture of what was going on, or rather should be regarded as complementary, with each contributing a different perspective on the phenomenon.

I considered spending time in institutional settings in order to observe the generation, prevention and management of incidents and then interview the staff involved. I thought that staff views on a recent incident in which they had been involved might reveal perspectives additional to those revealed when they were reflecting on incidents generally. Consideration of undertaking observation, however, revealed various practical problems. Extended periods of observation, even in acute care services, might have resulted in little, if any, data. As Marsh and Campbell (1982, p.1) have said: 'by and large violence is covert, fleeting and rarely performed for the analytical benefit of social researchers'. Another issue was the role to take along the participant to non-participant observation continuum. As a non-nurse I could not adopt the former. The non-participant observation position, however, presented problems. Firstly, there was the possible effect of my presence on the dynamics of ward atmosphere, perhaps of being a contributory factor to incidents, and on behaviour of staff both during an incident and at other times. Secondly, I envisaged that I could be a hindrance to staff in that had an incident occurred, staff resources might have been diverted to ensuring my safety at the expense of other pressing demands on their time. Given the foregoing, I concluded that it was not feasible to include an observation component in the study.

In many settings, documents can provide relevant perspectives on problems being investigated (Hammersley and Atkinson 1983). Since some of the national organisations involved in developing guidelines had suggested that health districts

devise their own to suit local circumstances. it was relevant to ascertain whether such guidelines existed in the case-study site and to ascertain staff perceptions of their usefulness. Records of violent incidents would provide an indication of the frequency and nature of incidents in different settings in the site. Furthermore, these records, combined with interviews with staff, might illuminate the question of record accuracy as considered by other researchers (Section 3.1.2 ii)).

4.6 INITIAL ANALYSIS STRATEGIES

A key theme in the literature on qualitative studies was that data analysis should be pursued concurrently with data collection, unlike quantitative research when analysis is undertaken after data collection is complete. Advocated by Glaser and Strauss as a key component of their grounded theory strategy (see Section 4.1.3), concurrent analysis was reiterated in several texts on qualitative methods (e.g. Hammersley and Atkinson 1983, Miles and Huberman 1984, Jones 1985b). Before starting fieldwork, therefore, consideration was given to procedures for recording and transcribing interviews and to a schedule that would allow time for concurrent transcription, reflection on data, and some preliminary analysis. The ways in which I followed advice about concurrent data analysis are described in Section 5.6.

The main decision to be made was whether to use a computer package to assist in the process of analysis. At the time, key UK texts (e.g. Hammersley and Atkinson 1983) sounded warning notes against using computer packages since these were relatively untried at the time, whereas their American counterparts (e.g. Miles and Huberman 1984) were inclined to favour their use. On grounds that most of my colleagues undertaking qualitative studies had opted not to use computer packages, these packages were relatively new, and my own computer literacy was limited at that time, I decided against their use in this study. This decision is reviewed in Section 11.1.3 ii).

CHAPTER 5: DATA COLLECTION AND ANALYSIS

This chapter focuses on decisions taken and procedures employed during data collection and analysis. As Miles and Huberman (1984) observed, validity and reliability in qualitative research depend largely on the skills of the researcher and several authors have observed that researchers should make their strategies public to demonstrate that conclusions are reasonable and well founded (Denscombe 1983, Burgess 1984, Walker 1985a). Site selection and details are discussed in Section 5.1 and negotiating access in Section 5.2. An orientation period is described in Section 5.3. Subsequent sections focus on the main fieldwork (5.4 to 5.7), data analysis (5.8) and presentation of findings (5.9).

5.1 SITE SELECTION AND DESCRIPTION

Using criteria discussed in Section 4.4, a list of possible health districts was compiled from current editions of the Hospitals' Year Book and the English National Board's handbook of courses and a clear first choice emerged. Before describing negotiations for access a brief description of the mental health services in the district is provided from information obtained from national and district publications and discussions with site personnel.

The health district was an inner city area and the population included diverse ethnic groups. Mental health services were based in a large psychiatric hospital, some specialist units and a range of community settings. The hospital was scheduled for closure and a programme of transferring patients to the community was in progress. The in-patient population was approximately 750.

Acute care services included two wards, one an open admission and assessment ward, the other a locked admission and intensive care ward. Continuing care services for adults included short-stay, medium-stay and long-stay wards; the designation of many of these wards appeared to be in a continual state of flux with the programme of ward closure. More than half the wards were for the admission and continuing care of elderly patients. Rehabilitation services comprised a residential hostel, a day hospital and departments offering industrial, recreational and occupational therapy. A team of

community psychiatric nurses (CPNs) visited patients at home and in group homes. and saw them at health centres. Other community services included a community mental health centre and specialist services such as behavioural therapy programmes. The senior nurse managers expressed concern about recent reductions in facilities for patients requiring long-term intensive care and were in the process of purchasing additional places in other institutions. Proposals to establish an interim secure unit at the site had recently been rejected.

The psychiatric nurse education school, located at the hospital site, offered the three-year Registered Mental Nurse (RMN) course, the two-year State Enrolled Nurse (Mental) (SEN (M)) course, and shortened RMN courses for those who were already registered nurses or enrolled nurses. Learners were employed by the health authority and their course comprised modules for each service. Each module involved a period of school-based study and a period of clinical experience.

During the fieldwork I sometimes felt extremely anxious. Such feelings can pose limitations on data collection and the impact of this on the conduct of fieldwork should be recognised and made explicit in the final account. Hammersley and Atkinson (1983) cite the observation by Olesen and Whitaker (1968) that most accounts read as if researchers glide through the process without a twinge of anxiety or a single faux pas, yet this is unlikely to have been the case. Following the position advocated by Denscombe (1983) I have incorporated discussion of my feelings and experiences on the grounds that these are an ongoing and integral part of research.

5.2 NEGOTIATING ACCESS

The process of gaining access is not only a prerequisite for doing research but also influences the validity and reliability of data obtained, and so awareness of the implication of one's actions is essential (Burgess 1984). Points of contact researchers have 'with an institution, organisation or group will influence the collection of data and the subsequent perspective that can be portrayed' (Burgess 1984, p.45). Moreover, events occurring during negotiations may influence people's perceptions of the research and their willingness to participate.

5.2.1 Aspects of negotiating access

i) Negotiating through hierarchies

In seeking access to formal organisations. such as the Health Service, initial negotiations are usually with those who have authority to grant permission, often referred to as 'gate-keepers' (Hammersley and Atkinson 1983, Burgess 1984). Negotiating access to formal organisations usually involves a 'top down' approach, since access to personnel normally requires permission from their line managers. Gaining access to psychiatric nursing staff entailed negotiating through a hierarchy of: district nursing officer; director of nursing services (mental illness); senior nursing officers and nursing officers responsible for the different services; ward sisters / charge nurses / heads of units; and registered and enrolled nurses working in the ward / unit / community settings.

I tried to be aware of interests of gatekeepers involved at each stage of negotiations since they were likely to want a favourable portrayal of the site (Hammersley and Atkinson 1983). Entering settings through someone higher in the hierarchy than those to be studied may raise questions about trust in the mind of the latter and possibly limit their willingness to be forthcoming (Walker 1980, Burgess 1984). Moreover, mistrust may be exacerbated if those in authority give permission without consulting those at lower positions in the hierarchy (Ball 1983). Consequently at each stage of negotiations I emphasised that although relevant line managers had given permission for the study to take place, individual participation was entirely voluntary.

ii) Constructing a research identity

People in the field seek to place researchers within their own experience in order to decide how to respond to them and consequently careful self-presentation is essential to maximise validity of data obtained (Hammersley and Atkinson 1983, Burgess 1984, Measor 1985). Researchers' identities may need to be carefully managed to avoid 'attribution of damaging identities and to encourage ones that might facilitate rapport' (Hammersley and Atkinson 1983, p.120). Moreover, it is crucial that researchers are aware of how they are perceived by respondents if they are to understand the status of their data (Ball 1983). I presented myself as a researcher, employed by a policy oriented research unit, seeking to explore a subject of much concern to nursing but about which little was known of views and experiences of learners and practitioners. As advocated by Gans (1968), Hammersley and Atkinson (1983) it is important to make clear from the

outset that the researcher does not pose a threat. Consequently, I emphasised that my role was to document and not evaluate, that I was not an expert on the subject of violence and that my skills lay in obtaining and presenting views of others. As others have advocated (Burgess 1984), I suggested that there might be advantages in the subject being explored by an outsider.

5.2.2 Initial negotiations for access

In response to a letter outlining the purposes of the DHSS funded project and my additional study, the district nursing officer (DNO) expressed willingness for the research to take place. The DNO undertook to inform the director of nursing services (mental illness) and the senior tutor for psychiatric nurse education that I would be contacting them directly about the research. Both these staff gave permission for the research to take place. Agreement was also granted by the district's ethics committee on condition that if staff were interviewed during their working hours, permission had to be obtained from the nurse in charge and that interviews would have to be curtailed if workloads necessitated interviewees' return. As this thesis is concerned with my study of staff and not the DHSS funded project on learners, further details relate primarily to the former.

Although I proposed to interview a proportion of staff (Section 4.4) it was agreed that all should be informed, not only out of courtesy but also because some would be asked to participate. Moreover, staff would probably encounter my research assistant and I while interviewing learners. Handouts about the research were distributed to all settings and meetings were arranged with nurse managers and staff. At these meetings, it was emphasised that: the purpose of the research was to document and not evaluate experiences and views; individual participation was entirely voluntary; and interviews would be held at times and places of interviewees' choosing. Reasons for preferring to tape-record interviews rather than take notes were given, as were guarantees of anonymity and confidentiality. The majority response was one of welcome that a subject of much concern to their professional lives was to be explored and of willingness to participate. Negotiations at setting level are discussed in Section 5.3.1.

5.2.3 Gaining insights

While negotiating access is a practical matter, drawing on interpersonal resources and strategies, it also has a theoretical component in that initial encounters provide information about patterns of social relationships that may be relevant to developing research designs and questions to be investigated (Hammersley and Atkinson 1983, Burgess 1984). My notes indicated a growing comprehension of the hierarchy of senior personnel, the psychiatric services provided, views held on the subject of violence and tensions between different staff groups.

5.3 THE ORIENTATION PERIOD

Once initial negotiations were completed the orientation period commenced. For the study of staff, its purposes were to decide on which settings and staff to include, review documents, gain an understanding of the climate, and further develop the interview guide. The orientation period was also used to make all the arrangements for the learner nurse project although details are not included here.

5.3.1 Sampling decisions

Following earlier consideration (Section 4.4), I entered the field with a reasonably clear idea of the services and staff appropriate for understanding the problem but with awareness that new cases might emerge as relevant and that some sampling of staff and settings would be needed. Once established on the site it seemed preferable to visit all settings before making decisions and a programme of visits was arranged. As others have experienced (Burgess 1984), offers made by senior personnel to inform others about research often do not materialise, or at least not fully. Not all staff had been able to attend a meeting and many staff knew little, if anything, about the research. The approach adopted, therefore, was to say that while staff may have heard about the research it might be helpful if I summarised the main points again. Those expressing willingness to participate were informed that interview arrangements would be made nearer the time.

During the visits it became apparent that some staff were extremely apprehensive about the possibility of being interviewed. Since the process of sampling staff in a setting might further increase their apprehension, I decided early on to interview all staff in a

smaller number of settings rather than a sample of staff in a larger number. On subsequent visits I stressed the importance of everyone's view being included and the hope that all staff would be willing to participate.

Of the two acute wards, I selected the locked ward since it admitted patients and provided intensive care on a short-term basis and records showed that it had the highest level of incidents. Of the two continuing care, long-stay wards, I selected the one that seemed most likely to remain a long-stay ward during the fieldwork. Of the short- and/or medium-stay wards I again chose one whose designation seemed likely to remain constant although this subsequently proved not to be the case. Of the rehabilitation services, the residential hostel and day hospital were staffed primarily by nurses and both were included. Community psychiatric nurses provided generic and specialist services and I planned to include about half of the former and all the latter. I planned to interview the nursing officer for each of these settings and four senior nurses with responsibilities across settings.

The staff interviews were scheduled to start in late 1986 with the majority planned for 1987. If all staff in the selected settings agreed to participate, a total of just over 60 interviews would be achieved. I planned to concentrate, as far as possible, on one setting at a time since becoming a familiar face over a short period of time, rather than appearing infrequently over a longer period, might lessen staff apprehension. Furthermore, since views and experiences might differ from one setting to another, concentrating on one at a time was thought likely to lead to greater understanding of each.

5.3.2 Reviewing documents

Documents identified as relevant to the study (Section 4.5.3) included guidelines and incident records. A copy of the local guidelines was obtained and questions about their availability and perceived usefulness were included in the interview guide. Access to records of incidents was requested in order to gain an understanding of their frequency and range (Section 4.5.3). Moreover, as Burgess (1984) and Saran (1985) maintained, interviews will be more fruitful if interviewees know that researchers have made an effort to be informed as far as possible about situations that they might encounter. I regarded this as important for the learner nurse project as well as the staff study.

Permission for access to records was requested part way through the orientation period by which time most senior personnel had expressed support for the research. Since these records might contain sensitive material I thought that request for access at the outset might jeopardise negotiations (Hammersley and Atkinson 1983). I planned to obtain information for the preceding three months for settings in which learners had placements and for the settings I planned to include in the study of staff. Sources of information included the Incident Report Book kept on each ward and staff casualty records. My research assistant for the DHSS project undertook most of the work involved in abstracting information from the records.

Experience in this study, although limited, corroborated earlier work about problems of completeness and accuracy of incident records (Section 3.1.2 ii)). When notes of incidents were checked against staff casualty records, several incidents included in the latter were found not to have been entered in the former. As the findings chapters show, staff offered reasons for incidents not being recorded. Although likely to be only a partial picture of the frequency of incidents, the records provided some indication of situations that staff encountered.

5.3.3 Understanding the climate

Gaining insights into frameworks which people might bring to interviews was important since, as noted in Section 4.5.2, these would need to be taken into account in decisions about interviewing strategies and interpreting findings. Possible aspects of such frameworks, identified from the work of several authors, included: patterns of social relationships and prevailing orthodoxies about the organisation's work; key historical and current events; and the impact of identities of researchers on participants (Whyte 1960, Gans 1968, Ball 1983, Beynon 1983, Denscombe 1983, Hammersley and Atkinson 1983, Burgess 1984, Jones 1985a, Measor 1985, Saran 1985).

i) Patterns of social relationships

Alliances and tensions may exist between and within different groups of people in a site and an awareness of these not only informs researchers about the social organisation of the site but also acts a signal not to become too closely associated with any one group, since to do so may jeopardise relations with others (Ball 1983, Beynon 1983 Burgess

1984). During the negotiation and orientation periods. alliances became apparent between certain groups of staff and tensions between others. Excessive rapport with one group may lead to analysis identifying with that group`s perspectives and failing to treat these critically, quite apart from causing problems of rapport with other groups (Hammersley and Atkinson 1983). Strategies to avoid becoming identified with particular subgroups, such as spending social time equally with each, were deployed. As Ball (1983) observed, contact with certain groups can be difficult if researchers do not have a base within which to conduct interviews. Having a small room on the site for this purpose was requested and of various locations offered, I accepted the one on neutral territory, a block for staff administering domestic services.

ii) Key events

With regard to past events, Ball argued that 'much of social life in a complex organisation like a school trades on the consequences and results of previous encounters, events and incidents' (Ball 1983, p.80). Although not known at the time of site selection, several violent incidents had occurred resulting in very severe injury to staff and I acknowledged awareness of these when interviewing staff. Some staff felt that they had been identified in a report of recent in-house research and expressed extreme distrust of research and a reluctance to participate during the visits to their settings. As others in similar situations have found (Beynon 1983), much effort had to be expended in reassurances that my approach would be different.

iii) Reaction to identities

The research identity I adopted was described earlier in the account of negotiations (Section 5.2.1 ii)). During the orientation period, I considered what image I should best portray through dress and manner to facilitate relationships with participants. Regarding dress codes, it has been suggested that researchers should signal that they seek to 'maintain the position of an acceptable marginal member, thus declaring essential affinity between researcher and hosts, without attempting to copy their style' (Hammersley and Atkinson 1983, p.79). In this site, dress codes for women were predominantly jeans for students and skirts and jumpers/blouses in muted colours for staff. I opted for a mid-position by adopting the staff style but in brighter colours. Reflections on how my ascribed characteristics of a white woman approaching forty might have shaped relationships with interviewees are included in Section 5.5.5 vii).

5.3.4 Further developing the interview guides

Draft interview guides for staff and nurse managers had been designed on the basis of the conceptual framework (Section 4.5.2) and were further developed in light of information gained during the negotiation and orientation periods. This included: the nature of key events; the perceived impacts of the locked ward on patient care; aspects of learner nurse education; and the high proportion of patients admitted to the locked ward under Section 136 of the 1983 Mental Health Act (a place of safety order). An interview guide was developed for nursing auxiliaries. The guide for nurse managers was developed into two guides: one for those with responsibilities for a single service, and another for those with responsibilities for several. The five interview guides are presented in Appendices 2 to 6.

5.4 FIELDWORK 1: ONGOING FIELD RELATIONS

Although negotiations are at their most acute in initial stages of research, they are likely to continue if access is required to several settings and to different groups of people (Hammersley and Atkinson 1983, Burgess 1984). In this study, arranging interviews took place throughout fieldwork and positive field relations had to be sustained.

5.4.1 Maintaining field relations

Researchers need to be perceived as credible if people are to be willing to participate and engage seriously with the subject (Beynon 1983). My credibility rested on my research track record (Section 5.2.1 ii)) and on what Beynon (1983) described as being willing to stay the course. I demonstrated the latter by visiting from the start of the orientation period, through the study of learners and then staff; a total of over 18 months. Length of time at the site also increased the likelihood of obtaining more detailed knowledge of subtle policies and undercurrents and reduced the likelihood of staff feeling threatened and wishing to maintain a pretence in my presence (Burgess 1984). Credibility was enhanced by interviewing all grades of staff and at times when convenient for them: often at the end of the late day shift or in the small hours of the morning for the night shift.

Researchers may have particular skills or knowledge of use to participants and this can contribute to facilitating access (Hammersley and Atkinson 1983). The study coincided with increasing emphasis on nurses' acquiring research skills. Those nurses at the site who were taking research courses frequently approached me for help with designing proposals and research instruments, analysing data and writing reports. While this certainly facilitated my reception. at times it proved extremely time-consuming, as others have warned (Hammersley and Atkinson 1983).

Various opportunities for casual conversation arose and were used to develop rapport since it can be threatening if researchers only talk about the research topic (Beynon 1983, Hammersley and Atkinson 1983. Measor 1985). I found several topics of common interest, particularly that of combining work and family. Difficulties in establishing trust may be due to people having bad experiences of research in the past and concerns that what they say to researchers will be made known to senior personnel (e.g. Ball 1983, Beynon 1983, Burgess 1984). Such events had occurred here and allaying fears that this would not be the case had to be ongoing throughout fieldwork and took considerable persuasion in some instances.

5.4.2 Maintaining distance

While the success of research may depend on amicable relations with participants, it also depends on maintaining a critical distance from them (Ball 1983, Measor 1985). Getting very close to participants' experiences of the world may lead to dangers of 'going native' (Ball 1983. Hammersley and Atkinson 1983) and it is important to maintain 'social and intellectual distance from the field since it is in these spaces that analytic work takes place' (Hammersley and Atkinson 1983. p.102). Opportunities for distance from the field arose in time spent in the site base and days when no interviews had been arranged for either the learner nurse study or my study of staff.

5.5 FIELDWORK 2: INTERVIEWING

5.5.1 Arranging interviews

Arranging interviews involved considerations of time and place. While researchers may prefer to plan interviews to fit their own work schedules. they have to accommodate interviewees' availability (Hammersley and Atkinson 1983). Many interviewees may be

more relaxed on their own territory (Hammersley and Atkinson 1983) but it is nonetheless important that the selected location offers neither distractions nor likelihood of being overheard (Hammersley and Atkinson 1983. Measor 1985). I offered people the choice of the site base, which fulfilled both criteria, or a location within their own work setting.

I visited staff in the selected settings to remind them of the study and arranged, with agreement of the nurse in charge, interviews for the next few days. All staff in institutional settings were interviewed in their workplace since they had to be available for recall if necessitated by workloads or emergencies. Some interviews could not be held when planned due to short-staffing or short-notice changes to the off-duty rota. Some interviews had to be abandoned before completion because of the ward workload or because the interviewee was called to an emergency on another ward. In all these situations, arrangements to undertake interviews, or complete those unfinished, were made for another time.

Arrangements to interview community staff were made directly with each person selected since they had more control over their own time. Some were interviewed in their office on the main hospital site, others in offices in community settings; all went ahead as planned. More senior people in organisations tend to have greater control over their time than junior colleagues and can be more flexible about the timing of interviews (Ball 1983, Measor 1985) and this proved to be the case in this study. Most managers elected to be interviewed in their own office although one opted to come to mine. (My office was used mainly for interviewing learner nurses).

5.5.2 Getting to and from interviews

During the early days of fieldwork I felt apprehensive when walking to interviews if I met one of the patients whom I had been told had a reputation for aggressive outbursts, although anxieties dissipated with time. Interviewing at night brought additional concerns. Distances between wards seemed considerable, some paths and corridors were not well lit, there was rarely any staff walking about and there had been problems with intruders in the grounds. Offers from male staff to accompany me to and from interviews were always accepted but often staffing was insufficient to spare a male

chaperone. Asked if I would be alright when about to leave unaccompanied, I always said "I'll be fine!" but left feeling very anxious.

5.5.3 Preparing for interviews

Prior to each interview I considered how frameworks that interviewees would bring to the encounter might influence their willingness to be forthcoming. During the orientation period and when arranging interviews I had made notes on the following: involvement of individuals in severe incidents of violence; feeling adversely affected by previous research; working on wards scheduled for closure; and appearing particularly nervous of being interviewed. I recognised, however, that current and recent circumstances, and the impact of these on individuals concerned, might not have been manifest.

5.5.4 Starting interviews

Although some advice on starting interviews emphasises taking charge in a calm and professional manner indicating that quiet and privacy are necessary so that both parties can concentrate (e.g. Morton-Williams 1985), it was sometimes difficult to put this into practice. My experience was similar to that of Measor (1985) who, having arrived at teachers' houses, found that they started talking about the research subject before she had chance to set up her tape recorder. In this study some interviewees started talking about violence as we walked to the designated interview location. This made it difficult to concentrate both on arranging seating so that I was half facing the interviewee to allow eye contact and observation of expression without forcing constant confrontation (Morton-Williams 1985) and on placing the recorder in the best position (Burgess 1984). In these situations I tried to remember what the interviewee said so that, like Measor (1985), I could return to the points subsequently.

Being interviewed can be daunting especially when answers are recorded, therefore obtaining valid data depends on the researcher's abilities to put interviewees at ease (Denscombe 1983, Jones 1985a, Measor 1985). To this end, I reiterated the purpose of the study, gave guarantees of confidentiality and anonymity, and explained that tape-recording would be more likely than note-taking to ensure an accurate record of the interview. Assurances were offered that I would agree to interviewees' requests that

particular views were not recorded and that only I, or possibly a transcriber, would listen to the recording (Burgess 1984). Most people agreed to be recorded.

5.5.5 Course of the interview

i) Interviewing strategies

Advice often includes starting with descriptive questions before moving to those that are evaluative, since the former are more likely to put interviewees at ease (e.g. Whyte 1960, Measor 1985). Consequently I started with questions about interviewees' nursing background, employment history, and details of their current setting before moving to questions about violence. While this approach usually worked, a few interviewees regarded questions about background as contravening guarantees of anonymity. A non-directive and open-ended style of questioning was used which aimed to stimulate interviewees into talking about broad areas while minimising my influence on what was said (Burgess 1984, Jones 1985a). Greater direction was sometimes used to aid clarification by summarising interviewees' responses and asking them if I had correctly understood what they had meant (Whyte 1960, Jones 1985a).

ii) Critical listening

While the role of researchers in open-ended interviews may appear passive, they need to be critical and attentive listeners judging, in light of interviewees' responses, appropriate directions to take, how far to pursue particular topics and whether to avoid others (Ball 1983, Hammersley and Atkinson 1983, Jones 1985a). I felt I became a better 'critical' listener as interviewing progressed, and developed increasing confidence to explore more sensitive topics that were emerging, such as views on patients' sexual frustration and its possible relationship with violence. Circumstances to facilitate critical listening were not always easy to achieve, particularly on the locked ward. Here interviews took place in an office that had windows on three sides and, during some interviews, patients would bang on the glass and shout at us. In these circumstances I found it more difficult to establish a relaxed atmosphere in which interviewees would feel at ease and in which I could concentrate on shaping interviews and picking up cues for probing answers further. Critical listening was easier when interviewees agreed to be recorded. When taking notes it was difficult to ensure these were comprehensive while also being alert for non-verbal cues such as expressions of unease.

iii) Length and rambling

Interviews varied in length from 40 minutes to two hours. I tried to keep them within two hours since it becomes difficult to remain a critical listener for longer (Burgess 1984, Measor 1985). My aim was to cover all areas with each interviewee to allow for comparability between and within settings. However, I was only interviewing people once and did not have the opportunity of a second interview to cover omitted topics except when returning to complete interviews that had been interrupted. In covering all topics it proved important to judge when people moved from providing relevant information and insights to 'rambling' (Burgess 1984, Jones 1985a, Measor 1985). Although I became more skilful at what Whyte (1960) described as interrupting gracefully and bringing people back on track, some interviewees had much to say on topics about which they felt strongly and it was sometimes difficult to move them on to another topic.

iv) Disclosing own views

Some interviewees expressed very strong views about actions of others over certain events. Given advice about not expressing one's own opinions in interviews (Whyte 1960, Measor 1985) my approach was not to do so but rather to act in accordance with advice that one should show understanding and sympathy without taking sides (Burgess 1984).

v) Anxieties during interviews

On the locked ward I initially felt anxious when left alone when interviewees had to assist with emergencies. On several such occasions patients came and stood in the door and talked to me. All I could think of was the advice often given in guidelines not to place oneself in a position where a patient stands between you and the means of escape. This seemed to be precisely the position I was in. I considered coming out of the office myself, but then might be in the way of staff coping with the incident. I considered locking the door but thought that when interviewees returned they would realise I had been apprehensive and this might destroy the professional image I was trying to present. The strategy I eventually adopted was to open the door as widely as possible and stand near it intently reading the notice board. Patients often did come and talk to me in this situation and gradually I became less anxious and got into conversation.

vi) Interviewing managers

Although my purpose in interviewing managers was to obtain their perspectives about violence in the settings for which they were responsible, this was not entirely successful. Most were long-standing members of staff and were keen to describe their experiences of violence over the years, particularly in the various locked wards that had existed. Two had only been very recently appointed to the setting for which they were currently responsible and had little to say about it. Observations made by these staff about specific settings are included in Chapters 6 to 9 as appropriate and their observations about settings as a whole in Chapter 10.

vii) Awareness of validity and completeness

An important part of critical listening is awareness of the validity and completeness of the interviewee's account (Denscombe 1983, Burgess 1984, Jones 1985a). I had given consideration to events that might affect interviewees' willingness to be forthcoming (Section 5.5.3) and once interviews started, I tried to be attuned to whether people were 'putting up fronts' and I was getting 'past the script' (Jones 1985a). I did feel that a few interviewees used such strategies, particularly at the start of interviews.

As people relaxed, however, the majority became more expansive and this was especially noticeable in relation to causes of incidents. Most staff were willing to talk about the serious incidents and some became upset when recalling events since they had been friends and colleagues of those involved. Critical comments were made about peers and managers and about certain hospital policies. Feelings of fear and distress were also revealed. This openness accords with experiences of others that once the researcher has been accepted, people are willing to 'spill the beans' and reveal institutional secrets (Beynon 1983). Moreover, people may enjoy having someone listening to them (Burgess 1984, Jones 1985a) and find the interview a valuable chance to offload 'pent-up feelings on the traumas of their working lives' (Beynon 1983, p.40). At the end of each interview I asked whether there was anything else that the interviewee felt relevant to the topic but that I had provided no opportunity to discuss. This sometimes acted as a trigger for revealing more sensitive material.

Another aspect of assessing validity of interview data is the impact of the interviewer's and interviewee's respective ages, sexes and ethnic groups on the interaction between

them. In some situations it may be easier to establish rapport with members of one's own ethnic group, in others a difference in ethnicity may prove to be an advantage (Hammersley and Atkinson 1983, Burgess 1984). Staff at the site included a wide range of ethnic groups and were used to working with diverse groups of colleagues and caring for diverse groups of patients. I gained no sense that when the interviewee's ethnic group differed from mine this adversely affected the encounter.

Each grade of staff from senior management to nursing auxiliary included both men and women and a wide age range. Some researchers have argued that women find it easier to gain access because they are seen as less threatening, and that they obtain better interview data from other women because they can be more empathic with their circumstances (e.g. Easterday *et al.* 1969). Others have suggested that women are more forthcoming when interviewed than men, irrespective of gender of interviewers (Ball 1983, Measor 1985). While I could not judge whether I obtained better interview data than a male interviewer would have done, I found men and women equally forthcoming. Given that I presented a consistent research identity throughout, I did not feel it necessary to adopt different approaches when interviewees' age differed from mine.

Overall I felt that most interviewees had talked openly, despite initial nervousness on the part of some. Like Measor (1985) I felt that the data were real and that in most instances I had not been 'fobbed off'. As interviews drew to a close, many staff expressed surprise that they had talked for so long since they thought that what they had to say about violence would take about 15 minutes. I tried to allow time at the end of each interview to check that all the topics had been covered, but some interviews had to be curtailed before I had time to do so.

5.5.6 Number and grade of staff interviewed

A total of 53 interviews were held. Four interviewees were senior nurse managers and included: the director of nursing services, responsible for all mental illness nursing services in the district; the assistant director of nursing services, responsible for all in-patient services on the hospital site; and the senior nursing officer and nursing officer responsible for all in-patient services at night. These interviewees, two women and two men, were all white with an age range from early 40s to late 50s and all had substantial experience. Interviews were held with the nursing officers for the acute services, the

medium-stay continuing care services. the long-stay continuing care services, the rehabilitation services and the community services.

High proportions of staff agreed to be interviewed on the locked ward (18/24), the continuing care, medium-stay ward (8/11), the continuing care, long stay ward (5/5) and the day hospital (2/3). Agreement proved harder to secure in the rehabilitation hostel (5/10), partly due to frequent staff turnover. In these five settings, those not included either declined at the outset or agreed to so do but then repeatedly cancelled the interview arrangements. Of the community staff, I included those working in specialist services and in the community mental health centre, and one of the 'generic' staff in each of the geographical areas in the district (a total of seven staff). For each setting, details of the nurse manager's profile and of the grade and profile of staff interviewed are included in the appropriate chapter.

I had intended to undertake all the above interviews myself but on six occasions was unable to do so. My research assistant undertook these six interviews instead but was not involved in analysis.

A few of the elderly care wards were included in the learner nurse study. I initially considered including them in my study of staff and some interviews were held to this end. Some of these interviews were also included in the initial stage of analysis. The findings indicated that staff perceived the issue of violence in the care of elderly patients very differently from that for adult patients; for this reason and also on grounds of length I decided not to include elderly care settings in this thesis.

5.6 FIELDWORK 3: CONCURRENT ANALYSIS

I followed advice about pursuing data analysis concurrently with data collection (Section 4.6). I reflected on each interview after completion, and I made notes on key points that had emerged and on initial analytic ideas. On the occasions when the interview had been undertaken by my research assistant, she shared her reflections on the encounter. Notes of interviews that had not been recorded were always written up shortly afterwards to maximise accuracy of recall. Recorded interviews presented the long recognised problem of keeping transcription on line (Whyte 1960, Burgess 1984,

Hammersley 1984). I attempted to get as many interviews transcribed as possible when working in each setting but left the rest upon moving to the next. The transcripts were typed verbatim with a wide right margin left blank for coding. Two copies were made; one was kept intact and filed in chronological order under setting, the other was used for subsequent separation into chunks of text.

A coding legend was developed from the conceptual framework (Section 4.3.2) and was applied to some of the transcribed interviews for each setting (the process is described in Section 5.8.1 i)). As with reflecting on interviews, the processes of transcription and coding gave rise to analytic ideas. These ideas, referred to as analytic notes (Hammersley and Atkinson 1983) or reflective remarks (Miles and Huberman 1984), were recorded, then every so often were developed into analytic memos. As the above authors observe, these accumulating analytic memos provide an initial framework to guide the main analysis. Part way through the interviewing, I drafted a preliminary paper on the basis of this early analytic work. Some of the categories emerging at this time were influenced by the learner nurse interviews as well as those held with staff and my research assistant had some helpful insights when commenting on this paper. The paper provided a useful basis when I returned to the analysis.

5.7 FIELDWORK IN RETROSPECT

As this account indicates, I did feel anxious at times during the fieldwork. I also found some of the interviews quite emotional experiences; some staff needed much reassurance that I would not disclose the content of their interview to their managers and some became quite upset over past events. My overall feeling, however, was one of enjoyment. Most staff were pleased the study was being undertaken, were helpful and hospitable and I enjoyed interviewing them. As an outsider to psychiatric nursing, I felt I had successfully negotiated access to staff and obtained their views and descriptions of their experiences in relation to a complex and emotive subject. Like others (e.g. Beynon 1983) I felt a considerable sense of loss when the fieldwork was completed and it was time to withdraw from the site.

5.8 POST FIELDWORK ANALYSIS

5.8.1 Approaches to the analysis

The post fieldwork analysis had four components.

Component 1: Producing an account of each setting by the dimensions of the conceptual framework.

Component 2: For each setting, developing a set of seven substantive categories. These were entitled: appropriate placement; knowing what to do; willingness to discuss; feeling valued; being supported; judging responses; and no win situations.

Component 3: Linking these seven categories through the development of a new category: implementing strategies concerned with the prevention and management of violence.

Component 4: Developing the seven categories and their properties (4a) and the linking category (4b) for the six settings as a whole.

The process of analysis (Sections 5.8.1 to 5.8.3) involved a considerable amount of moving between these four components rather than each following in sequence. In identifying the range of views and experiences relating to each dimension of the conceptual framework, and in generating substantive categories and their properties, I had constant recourse back to the data. The process required a willingness constantly to revisit and revise the various stages of the analysis. I wrote draft accounts at each stage since this process is itself a means of developing and trying out analytical ideas (Coffey and Atkinson 1996).

In a study of this kind, the development of categories is likely to be influenced by a diverse range of sources: existing theoretical perspectives; the analytic work of others; policy concerns; and the insights of the researcher (Section 4.3.1). This was the case here and the sources influencing the development of each category are included with their presentation in Chapter 10.

5.8.2 Initial analysis of each setting

I undertook the first two components of the analysis for each setting in turn, starting with acute care. Systems were required whereby each segment of text could be allocated to a dimension of the conceptual framework and to a developing category but still be

considered in the context of the interview as a whole. Many authors have described such systems and I drew on advice provided by. for example, Hammersley and Atkinson (1983), Mason (1996).

i) Acute care setting: Component 1: Account of setting

Gaining familiarity with the content of interviews before starting analysis is widely recommended (e.g. Ritchie and Spencer 1995, Mason 1996) and I read the 18 interviews through several times. I felt too distant from coding decisions made concurrently with fieldwork (Section 5.6.2) and hence re-coded these interviews. On each transcript, I drew lines round each segment of text that appeared to be a single statement about a topic. Each segment was kept as small as possible; some were a single sentence or phrase, others comprised several. Each segment was then allocated to a code and sub-code of the legend and this was written in the wide, right hand margin.

The coded transcripts were photocopied and cut up into the marked segments with their coded descriptors. Each segment was stapled onto an index card with details of the page of the transcript in which it was located and the interviewee's code to enable reconsideration in context. Interviewees had often referred to the same topic at several points in the interview, and increasingly I found that summarising the content of segments relating to the topic into one handwritten version on a single card facilitated my comprehension of what interviewees had experienced or felt. Each card was filed in a system that corresponded with the dimensions of the conceptual framework. As Mason (1996 p.108) observes, decisions about filing systems are not 'analytically neutral' and reflect assumptions or decisions already made about how data are to be analysed and presented. At this stage, I anticipated that the first stage of analysis, and possibly also the presentation of findings, would reflect nurses' views and experiences in relation to each dimension of the conceptual framework.

I repeatedly read all the cards filed under each dimension. This enabled me to identify its key themes and the range of views and experiences expressed in relation to each. In identifying themes I was drawing on the processes described thus by Ritchie and Spencer (1995):

> *'The researcher will be drawing upon a priori issues informed by the original research aims and introduced into the interviews via the topic guide, emergent issues raised by the respondents themselves, and analytical themes arising from the recurrence or patterning of particular views or experiences.' (Ritchie and Spencer 1995 p. 180)*

For each dimension, the content of each set of cards was then plotted onto a chart, with the interviewee numbers down the left hand side, the themes across the top and a brief note of content in each box of the chart. This approach drew on the system developed by Ritchie and Spencer (1995). For each theme of each dimension, the completed chart enabled me to identify the range of views and experiences and the number of interviewees expressing each. I then wrote a draft account for the acute setting on the basis of these notes amplified by the information on the cards.

ii) Acute care setting: Component 2: Developing substantive categories

As others had described (e.g. Jones 1985b, Mason 1996), developmental work on substantive categories takes place alongside analysing transcripts. In this study. some categories had begun to emerge during fieldwork whereas others emerged during coding of transcripts, charting of segments and account writing. An analytic indexing system using the first letter of the words of the working name of the category; for example AP for appropriate placement, was entered alongside the conceptual framework code. Once a category was emerging I allocated a separate sheet of paper for each and made a note of the content of all segments of text that related to it. These notes enabled me to see the range of data allocated to the category and to start identifying its properties. I wrote a first draft of categories and properties for the acute setting. Some findings contributed to the development of more than one property and were included in the account of each.

iii) Other settings: Components 1 and 2

I repeated the above processes for the other five settings. Although I applied the adjusted coding legend and the set of categories and properties developed from the acute care setting. I was mindful of advice (Jones 1985b) that these might not fit exactly and so expanded and revised both as work progressed. Rather than revising the previously completed setting. I worked on through all five. This was because further changes became apparent and I proposed reviewing these for the settings as a whole before revising each accordingly.

iv) Component 3: Developing a linking category

While analysing the rehabilitation services interviews, a link across the categories began to emerge. Many of the category properties focused on strategies for preventing and managing violence. Interviewees had talked about whether these strategies were ones that they were able to implement through their own actions within the setting or whether they required the action of others, for example medical staff or nurse managers. When strategies were not being implemented, interviewees sometimes offered reasons why this might be the case. At this point, I started a second sheet of notes for each category on strategy implementation. Personnel identified included the nurse in charge, other staff in the setting, medical staff, nurse managers and tutorial staff. Less specific references were made to managers and policy-makers with wider responsibilities than just mental health nursing service provision and education in this specific district.

5.8.3 Revisiting the analysis

i) Component 1: Accounts of each setting

The changes emerging as I worked through the five settings (5.8.2 iii) were considered as a whole. Having done this I then revised some of the themes for some of the dimensions of the conceptual framework, adjusted the coding legend and re-applied it to the transcripts. Rather than amending the original cards, this time I copied or summarised the responses onto a sheet of paper for each theme, using a word processor for the acute setting data. Inter- and intra- professional relationships were a separate dimension of the original conceptual framework (Section 4.3.2). When writing the revised accounts, it became repetitious to present findings on these relationships as a separate dimension as well as including them in other dimensions to which they related; for example, interviewees' views about medical staff taking note of nurses' views about patients' programmes of care. Consequently, findings on inter-professional relationships were integrated with other dimensions in the draft accounts.

ii) Component 2: Developing substantive categories

The changes emerging in relation to category and property development during the initial analysis were considered as a whole and a revised schema produced. During this process of revision, as others have described (Hammersley and Atkinson 1983), the categories underwent considerable change. New categories had emerged and some

existing ones were divided into two. Others were discarded as a separate category and some of their properties incorporated into the new categories. The seven categories listed in Section 5.8.1 had been developed by the end of this process.

The next stage was approaching category and property development more systematically and checking that the new schema 'fitted' the data and that my conclusions were well founded. There was a need to 'begin afresh' Mason (1996 p.121). I re-read the sheets of transcript segments and applied the category indexing system (Section 5.8.2 ii). As before, I had separate sheets of paper for each category and noted the content of segments of text relating to it, thereby enabling a comparison with all other allocated segments. Although the categories did not change again, I found I was able to allocate more segments of transcript to the category than during the initial analysis and to develop the properties of each category more fully. During this process, I also further developed typologies of properties for most categories; for example in the category *'Being supported'* a five-point typology was identified from 'able and willing to support' through to 'not recognising that support was needed'. This more systematic approach helped avoid what Lofland (1976) has described as undisciplined abstraction to concepts that bear little relation to the social world (cited in Jones 1985b).

iii) Component 3: Developing a linking category

A link across the categories, *'Implementing strategies'*, had been identified during the initial stage of the analysis while working on the rehabilitation settings data (Section 5.8.2 iv)). Whilst revisiting analysis, the development of this linking category was pursued in all settings.

5.8.4 Component 4: Cross-settings analysis

The fourth component of the analysis involved developing the seven categories and the linking category for the six settings as a whole.

i) Component 4a: Developing the seven categories across the settings

Using an A3 sheet of paper for each category, a column was allocated to each of the six settings. In the column for each setting, the properties for the category as developed in that setting were listed. This procedure enabled me to read across the settings and ascertain how the properties were manifest in the category for the data set as a whole.

This showed that nearly all properties occurred in the six settings whereas a few appeared in some settings only. I then wrote a draft account of the categories for the six settings as a whole.

ii) Component 4b): Developing the linking category across the settings

The linking category was developed across the six settings through a two-stage process of cross-classification. In Stage 1, the categories and their properties were listed down the left hand side of large sheets of paper and the settings across the top. In each box of the resulting matrix, for example acute care - appropriate placement, a note was made of personnel identified as responsible for implementing strategies. In Stage 2, the personnel identified were listed down the left hand side of a large sheet of paper and then all the strategies associated with them summarised across the rest of the sheet. This enabled me to see the range of strategies associated with each type of personnel and to allocate them to broader groupings. For example, strategies associated with nurses in the setting were grouped into responsibilities for their own expertise, responsibilities for contributing to the setting climate and responsibilities for liaising with personnel outside the setting.

5.8.5 Clarifying the research problem

At the outset of the study, the research problem was that not enough was known about nurses' views and experiences in relation to violence and that such information was needed to contribute to policy development in this area. By the end of the analysis, the focus of policy development from the perspective of nurses involved in direct patient care had become clearer: that nurses are faced with violence whether or not they contribute to generating it but that not all strategies to prevent, reduce and manage it lie within their sphere of responsibility to implement.

5.9 PRESENTING FINDINGS

During the analysis, I considered how best to present findings in the final account. There appeared to be three possible approaches. The first was to follow the stages of analysis and drafting. For each setting, there was an account of findings presented by the conceptual framework and the category development for that setting. There was then an account of the categories for the six settings as a whole. The merit of this

approach was twofold: since aspects of the findings were specific to the context in which they occurred they seemed to be more meaningful when presented as such: and the approach enabled readers to follow my process of analysis. The major disadvantage of this approach was repetition and length.

A second approach was to present data for the six settings as a whole from the outset: first, by each dimension of the conceptual framework, for example 'explaining violence' or 'post-incident events'; and second, by the substantive categories. Although I drafted a partial account to this effect it became just as long as the first approach but more confusing. This was because I needed to make clear where each finding had originated; for example, 'the charge nurse in the locked ward' said this and 'the charge nurse in the day hospital' said that. The third approach was to present the data by an expanded version of the substantive categories only. As with the second approach, however, the importance of demonstrating how each category had developed from the findings required indicating where each finding had originated and provided no benefit in terms of length. Both the second and third approaches lost the sense of the uniqueness of the different settings in which interviewees worked and associations between dimensions of the conceptual framework as it pertained to the setting; for example, perceptions of strategies available to manage incidents when most staff were relatively inexperienced.

In reaching a decision I drew on a discussion by Coffey and Atkinson (1996) by considering what I felt was most important to convey. I included an account for each setting of findings presented by the conceptual framework (Chapters 6 to 9) followed by an account of the substantive categories for the settings as a whole, written in a manner that enabled readers to follow how each was developed from the different settings (Chapter 10). The final account therefore includes what I regard as the key elements of the study: nurses' views and experiences about violence in the very different settings in which they worked; and the development of substantive categories that represented patterns across these settings.

The dimensions of the conceptual framework and associated findings are presented in Chapters 6 to 9 in an order that I felt made chronological sense. This is shown below with the number of the dimension as indicated in the original framework (Section 4.3.2) in brackets:

1. Features of the environment: the setting, the patients and the programme of care; staffing; and routes for admission. (Dimension 7)
2. Staff definitions of violence and aggression and the frequency and manifestation of incidents in the setting. (Dimensions 1 and 2)
3. Sources of guidance on which staff could draw: their own education and experience; district guidelines; and polices developed through discussion with colleagues. (Dimension 8)
4. Explaining and preventing violence. These were regarded as two separate dimensions in the generation and analysis of data but are presented together. This was because many of their themes were common to both; for example 'the interpersonal environment', and the 'programme of care'. For each such theme, findings are presented for explanation followed by those on prevention. (Dimensions 3 and 4).
5. Managing violence. I allocated responses about the management of violence to what I called primary and secondary management. The former referred to attempts to de-escalate incidents and the latter to actions taken when the former failed. (Dimension 5).
6. Post-incident events included recording, discussion and subsequent support. (Dimension 6)
7. Views about learner nurse placements included findings on placements in the setting and views about placements in the locked ward. (Dimension 8).
8. Feelings about violence included being scared and responses to patients who were aggressive to staff. (Dimension 9).
9. The balance between patients' and nurses' rights and views about the legal position of nurses. (Dimension 10).

As noted in Section 5.5.5 iii), although my aim had been to discuss each dimension of the conceptual framework with each interviewee, this was not always achieved. The process of charting the data (Section 5.8.2 i)) indicated the number of interviewees who had discussed each dimension as well as the number who had expressed certain views or described particular experiences. This information is included in the final account in order to demonstrate the extent to which conclusions are founded on the data set as a whole rather than being impressionistic (Miles and Huberman 1984, Silverman 1985).

In the process of breaking interviews into constituent segments the sense of the holistic nature of individual interviews is lost. Some interviewees had recounted specific incidents in considerable detail and analysis of these exemplified dimensions of the conceptual framework and contributed to the development of one or more of the substantive categories. Mindful of Coffey and Atkinson's (1996) advice that the inclusion of such narratives helps regain a sense of the holistic nature of the data, I included descriptions of whole incidents for those settings in which they had been described by interviewees.

CHAPTER 6: VIOLENCE IN AN ACUTE, INTENSIVE CARE SETTING

The setting selected for acute services was an intensive care unit. All interviewees referred to the unit as the locked ward and this usage is adopted here.

6.1 PROFILE OF INTERVIEWEES

Eighteen of the 24 staff were interviewed: one of the two charge nurses (CN), seven of the eleven staff nurses (SN) and all ten of the enrolled nurses (SEN). The one nursing auxiliary declined to be interviewed. Interviewees were evenly drawn from the two day-duty shifts and the night-duty shift. There were 12 men and six women with an age range from 26 to 56 and from a variety of ethnic backgrounds. Apart from a recently qualified SEN, time since qualification ranged from four to 16 years with all having worked on the locked ward for at least two years. The nursing officer (NO) was a white woman in her mid 40s who had been qualified for 18 years.

The CN stressed that working in this unit should be voluntary:

> *'To work with patients who are aggressive and violent, you've got to want to. You can't force someone to. You can't force someone to work in an environment like this.' (CN 1)*

Of others (10) who described their routes to the ward, all said that they had wanted to work here.

6.2 THE SETTING

All provided information about the setting.

6.2.1 Patients and programme

Patients were admitted direct from the community, from other wards and, less frequently, from courts, prisons and special hospitals to this 14 bed mixed sex ward. Descriptions of diagnoses included being acutely disturbed, psychotic, hyper-manic, suicidal, very deluded, depressed and in a drug-induced psychosis. In describing the aim of the ward (14), most referred to providing a short-term, intensive care programme for

acutely disturbed patients. Two stressed that the ward was inappropriate for patients requiring long-term care and the DNS described initiatives to purchase places in other institutions for these patients. The programme described (16) included: recreational and therapeutic activities; interaction with nursing and medical staff: medication: defusion of crises; and prevention of self-harm.

Most patients, about 60% according to the NO, were admitted directly from the community under sections of the 1983 Mental Health Act. A few patients were admitted under Section 2 (Admission for assessment), Section 3 (Admission for treatment), or Section 4 (Admission in an emergency), usually when acutely ill, and were transferred to other wards once this phase had passed. More commonly, patients were admitted under section 136 (a place of safety order) and at the time of fieldwork about half had been admitted via this route. Apprehended by police for behaving in a manner perceived as dangerous to themselves and/or others, these patients were placed on a section 136 by a police doctor. They were taken by police to the locked ward as the nearest 'place of safety'. Doctors assessed whether the section was justified and decided whether patients should remain, be discharged or transferred elsewhere. Most patients admitted from the community stayed for two to three weeks although occasionally longer.

Most interviewees (15) spoke about patients being transferred to the locked ward from open wards. These patients were described as disturbed (2), difficult (1), violent (2), aggressive (2), unmanageable (2), restless (1) and going berserk (1). Behaviour included smashing windows (2), attacking staff (1), screaming (2), shouting (1), and switching lights on and off (1). Purposes of transfers were described as giving patients time 'to settle down' (1), 'to have a rest' (1), to become more manageable (1) and as a deterrent (1). Reasons for staff requesting transfers included: lacking requisite skills to manage violence (5): having insufficient staff to cope (4): and reluctance to cope with such patients and wanting them cared for elsewhere (4).

Other, less frequent, routes included arrival direct from courts and from prison, secure units and special hospitals. The last two routes were for patients who had lived locally and were being placed in less secure environments as part of the process of discharge.

The ward comprised a day room. dormitory. kitchen, bathroom and two side rooms. Occasionally. an adjacent ward was used for activities requiring more space. Although always kept locked, some (3) commented that the ward was not secure, since the door could be kicked open if patients were sufficiently determined to escape. Ward size and layout were regarded as conducive to violence (Section 6.5.2). Locking the ward had three aims: protecting the public from individuals regarded as dangerous (4); protecting patients from harming themselves (2), and deterring violence by patients on other wards since this would probably result in transfer to the locked ward (1).

6.2.2 Nurse staffing levels

All interviewees spoke about staffing levels. The day-duty CN reported a minimum of six staff on duty, sometimes more and the SN in charge at night reported an average of five. Usually four men and two women were on the day-duty shifts, occasionally three of each, and one woman and three or four men at night. The NO found it difficult to ensure that sufficient men were on duty. Although male staff often worked extra shifts to provide sufficient cover (2), this practice was being reduced since staff were becoming too tired to be effective (1).

Adequacy of staffing was discussed by ten of the 11 day-duty interviewees and all the night-duty interviewees. A minority, three day staff and two night staff, thought staffing levels were adequate. Comments made by those who thought that staffing was inadequate related to explaining violence (Sections 6.5.4 iii) and iv)) and managing incidents (Section 6.6.2 ii)). Relationships between shift members were described (15) positively, with the phrase 'we are a good team' used most frequently. Those who said staffing was sufficient all attributed this to having a long-standing team. The DNS described the staff as a team that had confidence in each other.

The importance of having a team emerged in views about agency nurses. They were frequently employed on one of the day shifts, as several long-standing members had left, but less frequently on the other day shift and at night. Of those who discussed agency staff (9), all disliked having them on the ward, although two added that they did at least provide 'cover'. Dislike focused mainly on aspects of contributing to violence (Sections 6.5.3 ii) and 6.5.6) and managing incidents (Section 6.6.2 ii)).

6.2.3 Medical staff and nurse managers

i) Medical staff

A change from one consultant having overall responsibility for the ward to each consultant retaining responsibility for their own patients had caused difficulties and was disliked (8). Problems included: differing ideas about treatment making it difficult for nurses to develop an effective ward regime (2); numerous ward rounds disrupting nursing care (2); less streamlining of communication between medical and nursing staff (2); disputes over whose patient was most disturbed and required admission (3), and over transferring patients back to their own ward (1). The NO, however, thought it better for patients to remain with their own consultant when transferred since a change could exacerbate their condition.

All interviewees discussed working relationships between medical and nursing staff. While decisions about admitting patients and their subsequent care were made by doctors, views varied over whether they listened to and acted upon nurses' opinions; some described this positively (5), others negatively (4). Two interviewees said that doctors differed in this respect; junior doctors were more willing than consultants (1) and consultants differed one from another (1). The CN said that, overall, doctors listened to nurses' views on treatment more than previously and were involving them to a greater degree in admission decisions. Reflecting on why nurses did not have a greater role in decision-making, the CN attributed it to weak nursing management.

ii) Nurse managers

Those who discussed working relationships with nurse managers were more likely to be negative than positive. There was criticism that nurse managers had not involved staff in policy discussions relevant to preventing and managing incidents (4) and spent insufficient time in the locked ward to understand pressures that staff faced (2). The CN attributed lack of support to managers' insecurity because they were not supported by senior staff and to their loss of morale over uncertainty about the hospital closure schedule and the running down of services. Moreover, good managers had left and the less strong ones had remained.

6.2.4 Suitability for admission

i) Patients admitted under Section 136

Admission of patients under section 136 occasioned most concern (17). Nurses did not always agree with doctors' decisions to admit (3). Police were anxious to leave and often a lengthy period ensued until a doctor was available. During this period, nurses had to care for patients, many of whom were very angry at having been brought to the ward and consequently aggressive towards staff. Criticisms made of the police (8) included using the ward as 'dumping ground' (6), reluctance to wait until patients could be assessed by doctors (7) and inappropriate attitudes to nurses (aggressive, rude, sulky, argumentative, hostile) when asked to wait (6).

Admission procedures had recently changed following discussions between senior managers, medical staff and police. Patients now waited in an adjacent ward for assessment by a doctor and a social worker, and police and a nurse remained with them. Although this had reduced the number of 136 admissions, it caused additional problems (5); unavailability of social workers at night, nurses being at risk from attack by patients when separated from the rest of the ward team and the team being short staffed when an incident developed requiring the full staff complement. There was some resentment that managers had not discussed these changes with ward staff (2). It was not clear from interviewees' comments, and indeed they might not have known themselves, what level of nursing management had decided not to discuss these policies with them.

ii) Patients transferred from other wards

Over half (11) felt that requests for transfers were not always justified and that staff should be able to cope without recourse to the locked ward. Transfers sometimes created problems for the locked ward staff. Their own patients were disturbed by new arrivals (1), although agreement had recently been secured with medical staff that patients would not be transferred at night (1). Although staff had these reservations about accepting patients from other wards, one observed that they felt obliged to comply, since if an incident resulting in injury occurred on the ward requesting the transfer, the locked ward staff would be blamed if they had refused the request. Difficulties sometimes occurred over patients returning to their own ward, due to staff reluctance to have them back and/or their bed having been reallocated (3). Patients who wanted to return and could not, sometimes turned their anger towards the locked ward

staff (1). The NO. however, stated that problems did not exist over patients returning to their own ward.

Sometimes all consultants insisted that their patients remain on the ward, making it impossible to admit others who nursing staff thought required admission (1). The SN in charge at night provided an example of what he regarded as weak nursing management. When the ward was full, consultants sometimes insisted that nursing staff admit a patient into a seclusion room. If nursing staff refused, doctors rang the night-duty NO and said they wanted the patient admitted. The night-duty NO then rang the staff insisting on their compliance. In the morning, however, night-duty staff were criticised by the day-duty staff and NO for allowing this to happen since the ward was now overfull.

The NO and some interviewees (7) said transfer requests were decreasing. The reasons included a new manager insisting that open ward staff coped with violence (4) and locked ward staff visiting wards to assess whether requests were justified (1). Some (5) made suggestions to further reduce transfers including open ward managers requesting additional staff, senior management allocating more experienced staff to other wards, reviewing medication since it was better to sedate patients than send them to the locked ward and staff spending more time with patients since this would lessen the likelihood of incidents to gain attention. One observed, however, that this was a dilemma since staff were supposed to give less attention to patients on continuing care wards as part of preparation for discharge.

Various outcomes were identified were the locked ward to be closed. More staff would be needed on open wards (2) requiring more training in managing violence (1). Staff might leave through fear of danger to themselves (1) and there would be an increase in incidents on other wards now that the deterrent had gone (1). A secure unit would be required in the area (1).

iii) Specific patient characteristics

a) Patients who were not mentally ill. The CN thought that 90% of 136 admissions were justified and he would rather they were brought here than placed in a police cell. Others (6), however, felt that the system was abused when patients were admitted whom

they did not regard as mentally ill. Some should have been charged for causing damage or using threatening behaviour (1) while others were in drug-induced psychosis but were not mentally ill (1). Other interviewees thought it often not possible to know whether patients admitted in drug-induced psychosis were mentally ill until the effect of the drug had worn off (3). One questioned whether staff were qualified to manage these patients. particularly since they were often very aggressive. Some individuals had court cases pending and interviewees thought they acted in a manner likely to result in admission to a psychiatric hospital since they thought this might positively influence the subsequent court case (4). While in the ward, however. these individuals could be very aggressive towards staff:

'It infuriates us them coming in here, but what can we do?' (SEN 5)

b) Inappropriate treatment milieu. The ward was regarded as inappropriate for certain patients. Patients suffering from depression and regarded as suicidal, were sometimes further depressed by very psychotic patients (1). Other wards, however, had insufficient staff to provide the close observation these patients required and which was available on the locked ward. Some patients had committed violent acts but, in the view of staff, were unlikely to be violent again and required long-term care elsewhere (2). Other patients required long-term support in the community, for example in hostels with high staff-patient ratios but such facilities did not currently exist locally (1). Other patients, described as having a personality disorder and for whom a diagnosis of mental illness was debated, required behavioural therapy programmes that were not available on the ward.

c) Posing too great a degree of danger. Patients mentioned most often (9) were those regarded as too dangerous for staff to cope with, given their resources. Dangerousness was defined in terms of likelihood of assaulting others. The CN said that a few such patients were admitted each year and described a recent example of a man who had repeatedly assaulted staff. An SN described an occasion when he had refused to admit a patient he regarded as too dangerous despite the doctor asking him to wait for a medical assessment before refusing admission. When describing another admission, an interviewee remarked that one of the six policemen who had brought the patient to the

ward said the patient was too difficult for nurses to manage and should not have been admitted:

> *'He was too much for us too handle, we are only nurses, we are not here to use truncheons on the patients.' (SEN 2)*

While such patients were usually transferred to a secure unit or special hospital, it often took repeated requests from nursing and medical staff for a transfer to be effected (1), a point also stressed by the NO. The CN felt that secure units were very selective over admission, focusing on one-off murderers unlikely to be violent again. The locked ward staff, however, were expected to accept patients with a long history of violence who were often more aggressive than those placed in secure units. Moreover, they had to cope with them with fewer resources and a lower staff-patient ratio. An SEN concurred with this view:

> *'I don't think that's fair on nurses, to have that kind of violent patient, because this is not classified as a secure unit but nevertheless we have to keep them in this environment and we're not being paid to be a secure unit, but we are still doing the same work'. (SEN 4)*

6.3 DEFINITIONS AND INCIDENCE

Diverse definitions were offered of aggression and/or violence (13). The former included: verbal threats (2); violence against property (3); physical attack on another (2); unsociable, unacceptable behaviour (1); raised tone of voice (1); and self-harm (1). Definitions of violence included: physical attack (3) with injury or harm to people (1); an expression of aggression (2); carrying out verbal threats (1); an uncontrolled outburst (1); threatening with intention of hitting (1); and an act of frustration or of gaining attention (1). Four said that they found defining aggression and violence difficult and the NO that she did not have a definition of either.

Statements about frequency (8) included: incidents were frequent (5); they varied over time (3), and frequency depended on which patients were resident (2). The NO said the presence of particular patients made a substantial difference to her three-monthly incident report and that at night most incidents involved patients admitted on a section 136.

Most interviewees (15) described violent assaults. eleven referring to assaults on themselves. Assaults were manifest through punching (9) kicking (6). scratching (6), and less commonly pushing (2) biting (2) attempting to throttle (1) and stabbing in face with pen (1). Injuries included cuts, bruises, scratches and torn ligaments. Reference was made to sick leave after being hurt (2) with one interviewee needing a week and another a month. Verbal aggression was described as very frequent (7) and often of an abusive racial nature (7). Damaging property was more common than assaulting others (5) and manifest through breaking windows (5), throwing furniture (3). striking furniture (2), and kicking doors (1).

Although most incidents involved a single patient, some had involved several patients 'ganging up' against staff, particularly when the latter were engaged in restraining another patient (3). Relatives had threatened staff with violence over treatment of family members (4); sometimes waiting for staff outside the gates, sometimes coming to the ward. The NO observed that when relatives failed to understand why patients detained on sections could not go home they expressed their anger against nurses. Self harming incidents (3) included: patients smashing glass panes with their arms or hands and sustaining cuts of varying degrees of severity; cutting themselves with sharp instruments; biting and scratching themselves, or banging their head against a wall.

6.4 SOURCES OF GUIDANCE

There were three sources of guidance upon which interviewees could draw in contending with aggression and violence: their own education and experience; written guidelines. and discussions with colleagues.

6.4.1 Education and experience

Of those (12) who described their first-level education, five referred to learning during placements in acute settings, including locked wards with reference made to helpfulness of ward staff (2). Reflections on adequacy of school sessions (7) were more likely to be negative (5) than positive (1) with one interviewee unable to remember. Negative comments focused on lack of depth with which the subject was addressed (3) and advice given by tutorial staff that was found to be inappropriate in ward situations (4):

'When I was in school they used to teach you to pick up a chair and hold it in front of you, but that's not really practical because the patient will pick it up and hit you over the head with it. You have to go through that sort of situation to realise it.' (SEN 4).

Until recently there had been few post-basic opportunities with just one of those who spoke on the subject (11) having attended a study day. The CN observed, however, that a staff development rotation scheme, now no longer operating, had meant that staff nurses had gained experience of incidents when joining the locked ward staff for six months. Post-basic education on violence was needed (9) and subjects suggested included learning physical restraint techniques (6), awareness of meaning of violence to self (1), skills in minimising aggression (1), managing incidents (1) and counselling (1). Recently, opportunities for post-basic education generally had increased (5) and managers had decided that all staff on acute wards should attend a Control and Restraint course (3).

Of those who discussed (11) how nurses learn to prevent and manage violence, most (8) referred to learning from experience, as did the NO. All bar one had substantial experience of working in acute settings. Noting that many staff in the hospital did not have such experience, the NO said this meant that she could make little change to the existing staff group on the locked ward although felt that ideally no-one should work there for more than two years.

6.4.2 Guidelines

Of those who referred to guidelines (9), six expressed awareness of content. While two offered no criticism of content, others described recommendations as inappropriate:

'The written policy is very different to what happens in practice. You don't follow the recommendations when actually dealing with situations.' (SN 1)

Of those unaware of content, one had not seen the guidelines; one had previously seen them but was uncertain whether they currently existed, and the other said:

'I haven't read it recently. Things come in you know and you take a quick glimpse at it.' (SN 7)

6.4.3 Discussions with colleagues

A third source of guidance was discussion with colleagues at hand-over and after incidents (Section 6.7.2).

6.5 EXPLAINING AND PREVENTING VIOLENCE

All interviewees (18) discussed the explanation and prevention of incidents.

6.5.1 Patient attributes

i) Mental illness

Most interviewees (15) attributed some incidents to patient illness with reference made to psychoses, paranoia and depression. Psychotic patients responded with violence to hallucinations (5), hearing voices (5) and being deluded (1). Sometimes this violence was a response to beliefs that nurses were devils who should be attacked (2). Paranoia was sometimes manifest by violence against staff who patients believed were trying to poison them (1). Depression could make people want to be left alone (3) and be touchy and irritable (1).

ii) Substance misuse

Half (9) attributed some incidents to drug-induced psychoses caused primarily by smoking cannabis prior to admission. Mainly admitted under a section 136, these patients were regarded as particularly violent (9):

> *'They're the ones you have to be scared of, not the normal mental patient.' (SEN 2)*

iii) Antisocial behaviour

Some incidents were attributed to intent in that patients were aware of their actions (11); the phrase 'bad not mad' was often used in this context. 'Badness' was manifest by: aggression for no reason (3); manipulating people to become angry with each other (2); shouting and swearing (2); and being aggressive when staffing levels were low (3). Some patients were described as bad as well as mentally ill (5), for example having sufficient insight to assess when the ward was short-staffed and then 'playing up':

'He's mad, but he has a lot of badness with it - he can suss the situation and go for the nurses.' (SEN 3)

Other patients were regarded as being bad and not mad (9):

'I don't think she is mentally ill, she is just bad. She's aggressive to you, whether you are nice or nasty to her.' (SN 3)

The diagnosis of having a personality disorder was used in relation to antisocial behaviour (5). Explanations offered for this behaviour included: liking to hurt people (2); only wanting to please themselves and having no thought for others (2); a result of upbringing (2); wanting attention (1); not caring whom they hurt (1); violent here because behaved likewise outside (1); disliking calm environments and wanting to disrupt them (1); and having problems with conforming (1).

iv) Anger with circumstances

Some incidents were attributed to patients' anger with life circumstances (6) and included lack of housing and employment, family problems and anger at treatment by police.

6.5.2 Structural environment

The small size of the ward contributed to incidents (10), a view also expressed by the NO and the night-duty SNO. There was some resentment that staff had not been involved in decision-making when the ward was designated for admission and intensive care (2). Day-duty interviewees were more likely (8/11) to mention the problem of lack of space than night-duty interviewees (2/7). For the former group, lack of anywhere to sit quietly was mentioned most often (6) and included comments about space for patients to be alone (4) or talk to visitors (1) and for staff to take someone who was being aggressive (1). There was insufficient space for activities, such as dancing which would help relieve the tension that increased the likelihood of incidents (1). Only having one day-room meant that all patients and staff were in close proximity, getting under each other's feet, which made both groups tense (1). The closeness of patients to each other increased the likelihood of arguments and fights (1). Problems at night included lack of space for patients to sit quietly while others watched television and the

proximity of the dormitory to the day-room meant that those who wanted to sleep were kept awake. As one put it:

> *'It can exacerbate madness, badness and being on drugs.' (SN 6)*

The CN described how staff wanted a purpose-built unit that would have sufficient room for an increased range of activities and space for patients to have more privacy.

6.5.3 Interpersonal environment

Most (15) spoke about aspects of the interpersonal environment.

i) Ward atmosphere

The CN stressed the importance of staff creating a relaxed ward atmosphere as this would lessen the tension that could contribute to incidents. Personality clashes between particular patients and staff had to be recognised and staff allocated to work with other patients (2). When there were continuing problems between certain patients, staff requested that one be transferred to another ward (1). A consistent approach to patients was advocated since if one nurse agreed with a course of action desired by a patient and another disagreed, the patient might become aggressive with the latter (1). The DNS described the ward as having a relaxed atmosphere and attributed this to the long-standing and close relationships among staff.

ii) Nurse-patient relationships

Various points emerged from observations (13) about nurse-patient relationships. Appropriate behaviours (10) included being understanding, patient, tolerant, confident and having self-control and common sense. As one interviewee said:

> *'You have to be very patient and understanding. If you were explosive then you would have explosions all the time.' (SEN 3)*

Talking with patients (10) involved discovering problems, discussing current affairs, explaining treatment, reassurance and being prepared to sit with patients for a long time as some took a while to respond:

> *'Talk to them about the everyday world and what's in the papers and then they don't have time to be aggressive.' (SEN 2)*

Appropriate interactive styles included: using first names: not showing fear: treating as would a friend; treating as would like to be treated oneself; respecting them as individuals; being willing to listen; and being tactful, being affectionate and being firm:

> *'The approach should be on reasonably the same level as you would behave towards a friend. If you can't get to that level, there will be conflicts up the line.' (SEN 5)*

Styles of interaction likely to be provocative included: curt or hostile tone; not listening for long enough; being patronising; telling rather than asking patients to take medication; and approaching new patients before they felt ready to talk.

> *'Attitudes are very important. If staff are curt in their replies, the patient feels it and may respond accordingly, respond with verbal abuse or physical aggression.' (CN 1)*

Reasons offered (4) for nurses adopting provocative styles included: pressure of being 'endlessly pestered' by some patients; disliking particular patients; having an attitude of depersonalising patients; and bringing personal problems to work.

Constraints identified (4) on developing nurse-patient relationships included: insufficient staff to spend time with patients; drowsiness caused by high levels of medication making it difficult for patients to concentrate; discussions being difficult to pursue with very disturbed patients as they became too upset; patients staying too short a time for relationships to develop; and lack of information about different cultural practices and beliefs that could lead to misunderstandings. Nurses not meeting, or delaying, patients' requests, was mentioned (3) and one interviewee maintained that this accounted for 75% of incidents.

While seven interviewees thought that on occasions the nature of nurse-patient relationships did contribute to incidents, two added that this occurred most often with agency staff. Some agency staff had interactive styles that provoked incidents (2). Some were unaware when patients did not want to be approached (1). One patient felt provoked by certain agency staff (1).

An interviewee on the day-duty B shift felt that their CN did not provide sufficient feedback about patients' histories and progress, particularly in relation to violence, and this left staff feeling insecure about how best to approach patients. The ward was often too busy for all staff to read through case notes and if they all went to the hand-over meeting at which such information was discussed, the ward would be short-staffed. In her opinion, the CN was responsible for providing staff with relevant information and she contrasted him with the SN in charge when the CN was off duty and who did provide such feedback.

iii) Ethnic group and gender

Four points emerged from observations (12) about ethnic groups of staff and patients. Misunderstandings about intentions could arise when nurse and patient were from different ethnic groups and this could lead to incidents (2). Racially abusive language was encountered (7), most commonly white patients being abusive to black or Asian nurses. Several references were made to West Indian patients having a better rapport with West Indian staff than with either Asian or white staff (3): being more likely to attack Asian or white staff than West Indian (2); and being more likely to attack other patients than staff (1). One interviewee, however, felt that ethnic differences played no role in incidents.

Of those (5) who commented on gender and incidents, one felt gender was not relevant. The other four respectively observed that: male patients were more likely to attack male than female staff; male patients would threaten female staff but would not hit them; female patients were more likely to hit female staff than male staff; and male patients with a diagnosis of personality disorder would equally be likely to hit female and male patients.

6.5.4 Programme of care

Various aspects of the programme were identified in relation to explaining and preventing incidents (16).

i) Location

The most frequently cited aspect (14) was frustration and anger at loss of freedom. Some patients who felt better once initial phases of a psychotic episode had passed

became angry when not allowed to leave (2). Five interviewees commented that anger was expressed against staff:

> *'We represent authority, the people who stop them getting out, and it's taken out on us, even though we didn't put them here.' (SN 3)*

Other aspects of being in a locked ward included fear of what was going to happen, loss of personal possessions and being under constant observation.

ii) Medication

Medication was identified as a cause of incidents in that patients did not always wish to comply with prescribed medication (1). Medication was also referred to as a means of prevention (3):

> *'If someone really looks as if they're going to be a danger to self and others, then we call the doctor and say they need something to settle them down.' (SEN 7)*

Doctors were reported as coming to the ward to review medication when requested (2).

iii) Activities

Some incidents were attributed to boredom resulting from lack of activities and recreational facilities, and keeping patients occupied was identified as a preventative measure (9):

> *'Get them more involved in things, divert their attention and energies to something more constructive, more useful.' (SN 5)*

A night-duty interviewee commented that during the day patients could go for walks and play games in the adjacent ward but as this was not possible at night, patients were more likely to feel bored. Various constraints on having more activities were each mentioned by one or two interviewees. Aggressive patients often disrupted activities, and resources such as books were hard to obtain because they were often destroyed. Financial constraints were reflected in lack of equipment such as books. Input from occupational therapists was regarded as insufficient. While the CN was hoping to make a small garden outside the ward, concern had been voiced about patients having access to garden tools and he added a caveat that the scheme would only be feasible for patients

who were settled and when staffing was up to full complement. Occupying patients with tasks in the kitchen had been attempted but abandoned because hot drinks were thrown at staff. According to the NO, a constraint against patients leaving the ward for diversional activities elsewhere was that an increase in staffing would be required since patients would need accompanying.

iv) Staffing levels

Insufficient staff was identified as a cause of incidents (8). Some patients could judge if the ward was short staffed and responding by 'playing up' (7) whereas if they were aware that staffing was up to strength they were less likely to do so (5). When several patients appeared to be 'ganging up' a request was made for staff to be sent from other wards, since their appearance usually had the effect of patients backing down (2).

> *'If they see a certain number of staff, then they know that if they are aggressive they'll get restrained and they won't attempt it.' (SN 7)*

Insufficient staff meant lack of time to talk with patients and engage them in activities (4):

> *'I think people would feel more a sense of security that people were talking to them and again I think that would reduce violence that we are sharing the problem by at least listening.' (SEN 7)*

Furthermore patients could not be taken out for walks and so felt 'cooped up' (2).

v) Access to medical staff and information

Aspects of information were cited, each by up to three interviewees. Lack of information was mentioned, including patients being unable to see their own doctor or social worker to discuss their treatment, and lack of, or inadequate, information from doctors about treatment plans. When patients were unhappy with information provided by doctors about their treatment, the nature of their section or their length of stay, they expressed their anger against nurses. The CN felt that consultants spent too little time with their patients and attributed this to consultants' views that patients were too disturbed for effective communication hence time was better spent elsewhere. Providing relatives with information about patients' programmes of care was said to lessen the likelihood of relatives becoming aggressive (1).

6.5.5 Aspects of daily life

i) Insufficient food

Insufficient food was discussed by the CN and a night-duty SN. The CN observed that financial constraints had led to cutbacks in food and that patients' requests for more had to be refused. The SN said that these cuts meant that patients had insufficient food and that hunger made them angry. Unlike patients on other wards, those on the locked ward could not go out to buy food. If she gave them bread and butter when they were hungry, there would often not be enough for morning. If she did not meet requests for food, however, patients became angry.

ii) Sexual frustration

Towards the end of fieldwork on this ward, an interviewee observed that sexual frustration might cause incidents and identified a particular patient for whom he thought this was the case. I included the subject of sexual frustration in the two remaining interviews when prompting on explanations for incidents. While one felt it was a problem, the other did not since patients were not resident for long and, if it became a problem, they had opportunities to discuss it with medical and nursing staff. The latter interviewee appeared embarrassed by the subject.

The two who discussed the subject both regarded its resolution in psychiatric institutions as difficult. One felt that patients' sexual needs were ignored; the hospital had no written guidelines on the subject, and when it was raised with staff they responded with embarrassed laughter or by brushing the subject aside. He described his own approach as asking patients not to behave in a way which would be unacceptable in public; thus a 'kiss and a cuddle' was all right but not 'wandering hands'. The other said that staff discouraged sexual activity since family members might perceive that their relative had been sexually assaulted. He added that men could relieve sexual frustration by masturbation and that male patients and male staff laughed about the subject together. In his view female patients masturbated less often because they felt guilty about it. I should have asked him upon what this view was based but missed the opportunity.

iii) Relationships between patients

Relationships between patients that could contribute to incidents included: patients becoming irritated with each other (4); arguments over cigarettes (4): being disturbed by noise from other patients while trying to sit quietly or sleep (3): and jealousy occasioned by food and presents brought in by visitors for other patients (1). The NO described how a very disturbed patient could make others irritated and agitated.

iv) Visits from relatives

The NO observed that a frequent precursor to incidents was a visit by relatives that left patients feeling agitated.

6.5.6 Knowing and observing patients

Knowing patients well and being observant of their behaviour contributed to preventing incidents (8). Knowing patients had two aspects; knowing who was likely to be violent and knowing patients well enough to sense that an outburst was likely to occur. Good observation was described as the key to the latter in enabling nurses to be aware that a patient's behaviour was different from usual and to be alert for signs that might indicate the likelihood of an incident (5). The night-duty SNO described the locked ward staff as always on the alert for signs of violence and the NO regarded the ability to recognise these as the main skill that nurses required. Such information meant that preventative strategies could be deployed (4).

> *'How to identify a problem, sometimes you can notice it before it happens, you can sense it, you can see that a guy is going to blow at any time and then you can say: let's get to him now, let's have a chat with him and find out what's the problem.' (SEN 6)*

A reason for disliking use of agency staff was that they did not know patients well enough to predict incidents (1).

6.5.7 Incidents that were not preventable

Some interviewees (8) and the NO thought that incidents were not always preventable. Incidents could be unpredictable and sudden (5) or certain conditions militated against prevention (5). The latter included some aspects of mental illness (3), 'social misfits'

for whom the ward could offer no appropriate treatment (1) and those with personality disorders since they 'could never be cured' (1).

6.6 MANAGING VIOLENCE

All interviewees (18) spoke about managing incidents.

6.6.1 Primary management

Interviewees' (15) responses allocated to primary management included interpersonal skills, letting aggression run its course and medication.

i) Interpersonal skills

Ascertaining reasons for patients' anger and helping them calm down was mentioned most often (11):

> *'Listen and talk to them - talk them out of the aggression and calm them down.' (SEN 7)*

Offering tea and cigarettes was mentioned (1), as was holding patients (1):

> *'You can hold them, you can put your arm round them, hold their hand, try and contain them, not actually restrain them.' (SN 6)*

Reference was made (2) to calming down patients brought in by police:

> *'It's very important that you adopt a friendly approach to patients, however difficult they may be. I found that when patients had been brought in by the police, the story has been that they have been very aggressive and disturbed at the police station and once they come on the ward, we greet them and handcuffs are taken off and the patients are quite relaxed and you talk to them and its amazing how calming and settling that can be.' (CN 1)*

Not showing fear was stressed (3), one adding that patients sensed that staff were fearful and, concluding that staff might hurt them, responded with violence first. Observations by two male interviewees included the views that women could defuse situations just as well as men, and that women were sometimes better than men at calming down angry male patients.

Constraints in using interpersonal skills included: patients in drug-induced psychoses were much harder to calm down than other patients and staff had to wait until the effect of drugs had ceased (2); and while remaining calm and not getting angry oneself was important, this was sometimes difficult to achieve (1).

ii) Letting aggression run its course

Sometimes the best approach was to let aggression run its course (3). One spoke about verbal aggression:

> *'Verbal aggression isn't too bad, we let them rant and rave. We don't want to stop them in case they turn violent. It's best to let them get it off their chest and then we settle down and talk to them and see if we can find out what's wrong'. (SEN 7)*

Others felt damaging property was acceptable; for example, allowing patients to break cups and windows since it:

> *'brought out what's been building up'. (SEN 2)*

I should have asked these interviewees if this was ward policy and whether other staff agreed with this approach but missed the opportunity.

iii) Medication

Medication to manage incidents (6) was used when patients were violent on admission or became violent subsequently. The nurse in charge at night referred to difficulties in medicating patients in drug-induced psychoses since staff did not know which drugs they had taken and were concerned about adverse interactions.

6.6.2 Secondary management

Interviewees' (18) responses allocated to secondary management included decision-making, staffing and summoning help, and interventions used.

i) Decision-making

The day-duty CN and the SN in charge at night discussed their role in decision-making. Both said that if an incident appeared likely, it was their responsibility to decide what course of action to adopt and direct others accordingly. As the CN explained:

> *'If it's a stand-off, if someone is threatening a nurse with a [billiard] cue, then it is up to me to do something, it's my responsibility, that's how I see it.' (CN 1)*

The SN emphasised having confidence in oneself and being prepared to defend one's decisions. Both referred to incidents developing suddenly that necessitated a swift response without time for forward planning. In such situations, for example when immediate restraint was necessary, they described directing each member of staff to undertake a specific task such as preparing an injection or calling a doctor. The CN added that sometimes staff nearest to hand acted when incidents developed suddenly and called him if necessary.

From knowledge gained from working as an agency nurse on the opposite shift, a day-duty interviewee contrasted decision-making on the two day shifts:

> *'I found our shift prefers to try and talk things down and try and persuade people to take medication, really even if it's [it takes] three or four hours, we'll do it. Whereas the other shift goes a wee bit straight-in [i.e. restraint] and asks questions later.' (SEN 10)*

In discussing decision-making, other interviewees (10) referred to incidents needing immediate response. First they moved swiftly to the scene:

> *'When an incident starts we all go - everybody drops what they are doing and goes, quickly we all get together.' (SEN 3)*

When asked if they then needed guidance, all replied in terms of knowing instinctively what to do as a result of being a long-standing team:

> *'It's informal. Its not so much someone shouting out instructions, usually you find everybody knows. That happens once you've got a team that you know and that you work with well.' (SN 7)*

The NO, like the two nurses in charge. described a more structured approach with nurses providing information to the nurse in charge who then made a decision about the action to take and directed each staff member accordingly.

ii) Staffing and summoning help

Aspects of staffing discussed in relation to managing incidents included adequacy and support.

a) Adequacy. The SN in charge at night described difficulties when he felt that threatening behaviour might turn to physical violence but had only three men on duty:

> *'You don't know how to act. If you haven't got the manpower behind you, it puts you in a situation where it can take you half an hour to decide what to do and in that time the patient is restless, waking everybody up.' (SN 6)*

Prior to restraint or seclusion, extra staff were usually requested from other wards (9), specifically extra men (3):

> *'If someone becomes violent you have to get extra men in and if they are very strong you need men when you have to give them an injection.' (SEN 9)*

Day staff said that managers sent help to the ward when requested. Although the SN in charge at night criticised night-duty managers for sometimes failing to provide more staff thereby leaving them in a vulnerable position, others commented that night-duty managers sent extra staff when requested and/or came to the ward themselves (4):

> *'If you've got trouble in the block they are there in minutes to support their nurses. They don't hang back.' (SEN 6)*

Another commented that managers could not provide staff whom they did not have. When managers perceived the ward as being 'quiet' they transferred one member to an understaffed ward but this failed to take account of the speed with which dangerous situations could develop requiring the full complement of staff (1).

The importance of team-working when managing incidents was cited as a reason for disliking the use of agency staff (5). Concerns centred on agency staff not knowing what to do if an incident arose (4) and standing back because they were frightened:

> *'We are apprehensive when we have agency staff in case they don't know how to deal with a dangerous situation when it crops up. They might not pull their weight at the right time and someone might get hurt.' (SEN 4)*

The night-duty SNO expressed concern that agency staff employed at night were sometimes inexperienced in dealing with violence.

b) Support. Aspects of support included cooperating with decisions made by the nurse in charge about incident management (2) and supporting a colleague who had started managing an incident (5):

> *'When you need help your colleagues come as quickly as possible to support you.' (SN 1)*

A team of people who knew each other well and knew what to do in a crisis was seen as essential for working in locked wards (2):

> *'On a disturbed ward you need regular staff who know what to do at the right time and work as a team ... A regular team is at the heart of it.' (SN 5)*

Benefits of having a supportive team included feeling less fearful when facing incidents (4) and wanting to continue working on the ward (2).

iii) Restraint

All interviewees discussed managing incidents through restraint.

a) Reasons and aims. Situations necessitating restraint included: patients assaulting staff; patients assaulting each other; self-harming; 'ganging up' on staff and, less specifically, being 'very violent' or 'very aggressive'. Aims were preventing patients from harming themselves, other patients or staff and avoiding injury in the process (3).

b) Process of restraining. I tried to ascertain how restraint was coordinated in the sense of each nurse involved knowing what to do and whether the nurse in charge

directed each to hold a particular limb. All those (8) who gave details said that they were not thus directed, rather that they just did it:

> *'Everyone seems to know their position whenever anything happens.' (SN 2)*

Emphasis was placed on quickly gaining control of the situation (4) and thus it was unrealistic to wait for instructions (3). A night-duty interviewee contrasted restraint techniques used at night with those during the day:

> *'Here if I have to put a patient down, I can put my knee on his cheek, but they wouldn't be able to do that on days. They'd have to go and find a pillow to put underneath his head and all that.' (SEN 8)*

In his view actions were subject to greater scrutiny during the day since doctors were sometimes present. Two men and two women said that male staff usually undertook restraint while women prepared injections and opened the side room doors.

c) Learning physical restraint techniques. Some interviewees (7) spoke about learning physical restraint techniques. Means of learning (4) included: having no formal teaching (2); picking it up (2); developing a ward routine (1), and being shown a 'ludicrous' training film on how to restrain (1). Content of learning (5) included: using minimum force (2); holding patients' joints to prevent movement (1); holding elbows (1), and restricting movement (1). Most (6) felt that training was needed:

> *'We tend to do it OK - but training would help. For us to work effectively, we all need to have the same approach. So when we tackle someone we all do it together. Sometimes we waste vital minutes trying to get them to the floor.' (SN 3).*

The recent management decision for staff to attend Control and Restraint courses was approved (3), although one cautioned that staffing levels might make this difficult.

d) Staff injuries during restraint. Staff were occasionally injured during restraint and two described being hurt. In one incident the interviewee broke a finger:

> *'He was punching one of the fellow patients. [Name] and I grabbed him and in grabbing him and restraining him, we all fell to the floor and*

afterwards my finger was enormous. I couldn't tell anyone how it happened, whether I fell on it or he fell on it.' (SN 4)

A more serious injury of cracked ribs, necessitating a month's sick leave, had occurred when the interviewee was nearest the incident and had to act swiftly alone in restraining a patient from attempting to throttle the charge nurse.

Likelihood of injury was increased by ward layout (2). There was insufficient room safely to manoeuvre patients in a restraint (1). The side room doors were very narrow and injuries had been sustained by staff squeezed between the doorframe and another person when moving a patient into these rooms (1). Patients were occasionally injured (Section 6.10.1 ii)).

iv) Medication

After restraint patients were usually given medication (8) with one interviewee commenting that this happened in 90% of cases.

v) Seclusion

Seclusion was discussed (10) in terms of reasons for use (6) and frequency (4). Reasons for benefit of those patients secluded were their own safety and to help them calm down. Reasons for benefit of fellow patients were ensuring their safety and avoiding them becoming distressed. Other reasons for using seclusion included: inability to calm patients through restraint and medication; desperation when short-staffed; deterrence against future violence; and dislike of patients exposing themselves. Seclusion was used much less frequently than in the past (4); this was attributed to policy changes, more emphasis on interpersonal skills, and better staffing levels. The NO remarked that seclusion was taken very seriously, was used only as a last resort, and she would always be informed of its occurrence.

6.7 POST-INCIDENT EVENTS

Most (16) discussed post-incident events: recording the incident (10), discussions (13) and support (3).

6.7.1 Recording incidents

Views differed over whether all incidents were recorded in the ward incident book (5) or only those in which someone was assaulted (1). Another two felt that incidents were under-reported; one added that more should be recorded, otherwise a false impression was created, while the other offered an explanation for under-reporting:

> *'If you get a patient who is always violent, always abusive then the staff get fed up writing about it and then it gets under-reported, and sometimes it gets under-reported if for example you have planned to discharge someone tomorrow. You don't want to make a big fuss about it and say "Oh, you've been bad", you say "Well he's been fairly good and the sooner he goes the better."' (SEN 8)*

Two night-duty interviewees described staff discussions about incident reports. While one said these enabled staff to write a report to inform other personnel, the second focused on producing a consistent account when staff from other wards had participated:

> *'The way things are, you have got to be sure what you are saying. You can't just put things in writing and not be sure. If we have got help from upstairs we want to know that the staff we have called understand what we are going to say or what we are going to write. They might not have been here when the incident actually started.' (SEN 8)*

6.7.2 Discussing incidents

i) Discussions within shift

Three points emerged from responses (13) about staff discussions: frequency (13); benefits (8); and reasons for not having discussions (4).

a) Frequency. Differences emerged both between and within shifts over whether post-incident discussions were held. All the day-duty A shift interviewees who commented (3) said that discussions were not held on their shift and two added that they would like them. On the other two shifts, however, of the five who commented, four said that discussions were held, some adding that this was only when someone had been hurt, but one said discussions were not held. The NO recognised that staff did not always systematically discuss every incident but she thought that they should.

b) Benefits. Staff support and improving practice were identified as benefits of having discussions (8). A recently qualified SEN on the A shift said that staff felt shaken up

after an incident and that discussion would help restore morale. I suggested that his feelings might be due to insufficient experience and that other, more experienced, staff might not feel likewise but he responded that they were also shaken up. In similar vein, the SN in charge at night, said that discussions helped build up staff morale when they had felt frightened. One interviewee said that talking to other staff helped her get rid of anger felt when patients hit her without reason and another, involved in a particularly distressing incident, had found it helpful when the CN encouraged him to discuss events at length.

Sharing of views and experience were said to benefit practice by first identifying causes of incidents so future occurrence could be avoided and second, by improving ways in which incidents were managed. The recently qualified SEN had suggested having a form to record key points of incidents as a basis for subsequent discussion that sought not to blame individuals but to consider whether staff might have acted differently.

c) Reasons for not having discussions. Reasons offered included familiarity:

> *'Because we get used to them, everyone more or less knows why, what and how.' (SN 4)*

Another reason was reluctance by both CNs. The SEN who had proposed having an incident form reported that the CN was unwilling to have the idea discussed at a staff meeting:

> *'And you sometimes feel they don't want to hear your ideas, you come to jobs enthusiastic and try and make things better, but the response to that was nothing.' (SEN 10)*

An interviewee on the other day shift said staff had requested a weekly meeting to discuss incidents and the stress these caused staff but that the CN only held such meetings occasionally. When asked whether these meetings were helpful, the interviewee hesitated and said that they could be difficult. Reluctance among staff was attributed to some having previously been violent themselves and for whom the discussion would recall painful memories (1) and lack of willingness to consider violence in the context of nurse-patient interactions (1). The NO felt that pride was a

constraint against discussion and that men in particular did not like to admit that they had been hit.

ii) Discussion between shifts

The oncoming shift was informed about incidents and patients whose behaviour warranted close observation (8). One interviewee, recently qualified, expressed concern that different rates of seclusion, restraint and post-restraint medication between the two day shifts were never discussed.

iii) Discussion with nurse managers

Day-duty interviewees (3) reported that their NO did not participate in post-incident discussion, two adding that provision of counselling by the NO for those involved would be helpful. The NO described the situation as one in which staff did not always call her to the ward to discuss incidents. Night-duty interviewees (2), however, said that their manager had spent time talking with staff involved in incidents.

iv) Discussion with patients

Nine interviewees, some from each shift, spoke about discussing incidents with patients. It was striking that on each shift some said that such discussions were held whereas others reported this not to be the case. Of the former group (6), two added that this usually occurred when patients had calmed down. The aim was to ascertain why incidents occurred; sometimes patients were able to identify the problem, sometimes they had no idea what had provoked them. Of those (3) who said incidents were not discussed with patients, one went on to say that they should be. Some patients were reported as apologising to staff after they had calmed down (3).

6.7.3 Post-incident support

Greater awareness was needed that nurses hurt in incidents might need a short break from the ward to recover (1). The NO, however, said she advised staff to have a break and relax but observed that it would be unrealistic to attempt reassuring staff by stating that incidents were unlikely to reoccur.

Sympathy offered by colleagues to injured staff on sick leave was contrasted with that offered by managers. The latter were regarded as focusing on staffing implications

rather than concern for the individual (2). The interviewee who had needed a month's sick leave following injury to his rib said that colleagues had visited:

> *'but not senior management. They didn't get in touch. There was no sympathy or empathy. They were just cross because the ward staff were depleted. That comes across.' (SN 4)*

6.8 LEARNER NURSE PLACEMENTS

Learners did not have a locked ward placement, although they had done so previously. At present they just visited the ward and had a discussion with staff about violence. Most interviewees (14) discussed their views about placements.

6.8.1 Reasons for not having placements

The CN said that placements ceased because the current tutors opposed the existence of locked wards and thought them inappropriate for learners and the English National Board regarded this locked ward as inappropriate since too many consultants shared responsibility for patients. An SN, however, thought the reason was learners having been involved in violent incidents and tutors criticising lack of subsequent discussion. The NO felt that the increasing emphasis in the curriculum on caring for people in the community meant that acute inpatient experience was neglected.

6.8.2 Views on providing placements

Diversity of view existed over providing placements with seven in favour, four ambivalent and three opposed.

6.8.3 Reasons for favouring placements

Of those favouring placements, or expressing ambivalence, most (8) and the NO described the importance of students gaining experience likely to be needed once qualified. A placement provided opportunities to see incidents developing and how staff managed them and to be involved in post-incident discussions. The CN said that denying learners a placement set up a cycle of inexperience in that if learners did not gain experience of preventing and managing incidents, they would lack confidence in this respect once qualified. Consequently, when such incidents arose on wards of which they had charge, they would send patients to the locked ward since they lacked

experience to cope. This in turn deprived learners on these wards from gaining experience. He described the current session as inadequate:

> *'They need to be placed in the environment, feel the environment and get used to the tension.' (CN 1)*

The CN said that previously. learners soon lost their fear and gained confidence in managing minor incidents.

6.8.4 Nature of placements

Views about placements, were these to be recommenced, included: learners should only come if they wanted to (3); they should not come until their final year (3); they should visit the ward before deciding to come (1); the placement should be three months (1); and they should come on the understanding that they were there to 'learn' and not 'cause trouble' (1).

6.8.5 Reasons for opposing placements

Three reasons were offered by those opposed to, or ambivalent about, placements (7). Learners might be hurt through inappropriate approaches to patients and when involved in restraint (3). As one of them said:

> *'You need people who can cope rapidly, rise to the occasion.' (SN 5)*

A second concern was learners possibly misinterpreting restraints as being unfair to patients (4). Interviewees aimed to gain control of situations without injury, yet learners had reported their actions to tutorial staff as inappropriate. The latter had supported learners and raised the matter with nurse managers who had sometimes instigated inquiries. The consequence, in one interviewee's view, was nurses being afraid of working with learners. Thirdly, nursing management regarded learners as replacing staff and moved a qualified staff member to a short-staffed ward, thus leaving the locked ward short of its qualified staff complement (1).

6.9 FEELINGS ABOUT VIOLENCE

Seventeen interviewees discussed their feelings about violence. Aspects explored included feeling at risk; feeling scared; feelings towards patients who threatened or attacked them; and feelings about the work environment.

6.9.1 Staff safety

Of those discussing whether staff safety was at risk (10), just one felt it was not and attributed this to high staff-patient ratios and teamwork. Perspectives emerging from others included the working environment (5):

> *'We are in a very dangerous situation here. We're being faced with a dangerous situation every night, the potential for danger is always there.' (SN 7)*

A second perspective was comparative risk (5). Some felt at risk but less so than on open wards to which patients could bring weapons (1) and outside the hospital because of street violence (1). Others (3) including the NO, however, felt they were more at risk than staff on other wards and than staff in secure units where there was a higher staff-patient ratio (1). One felt that risks on the locked ward were increasing as a long-standing team was breaking up and said that a recent departure had been occasioned by concern over increasing use of agency staff.

> *'I am happy, but now with people leaving I am getting anxious. I don't want to work with people I don't know. If there is a regular team here I don't mind, but with staff leaving I am anxious, you could be in danger here, you see.' (SN 5)*

6.9.2 Feeling scared

The six women and ten of the 12 men spoke about fear. Most, five women and seven men, said that they were scared occasionally, some (5) adding that the degree of fear depended on the nature of incidents. One man added that men found it difficult to admit being scared and that had I interviewed them as a group, rather than individually, none would have admitted this, including himself. The CN, and an SN occasionally in charge, commented that even when scared they had to take responsibility for managing incidents.

Patients who were feared included: those known to be aggressive and violent (2): patients whose violence was unpredictable (2); patients not known to staff (2); and patients in drug-induced psychoses (2). Situations, described by one interviewee each, included: being threatened with billiard cues; knowing that angry relatives might be waiting for them outside the ward; anxiety as to whether staff could cope; fear that colleagues might get hurt; when the ward had a 'disturbed' atmosphere; and when agency staff were on duty, through fear that they might not know how to deal with a dangerous situation and consequently someone might get hurt. Two referred to situations when patients 'ganged up' on staff, the CN describing this as the situation that staff feared most.

Two male interviewees observed that several male staff, including themselves, were of small stature whereas many patients were large and heavily built and that this contributed to feeling scared. Sometimes staff felt more scared after incidents than when actually dealing with them; for example, when a patient had pulled a bed apart and thrown pieces of it, one said:

> *'I wasn't scared at the time but when I thought about it afterwards if any piece of the bed had hit somebody it would have taken their head off. At the moment when something is happening and you are dealing with it, you haven't the time to be scared.' (SN 7)*

Describing factors that lessened fear, interviewees (5) included good team work (4), experience (3), familiarity (2) and high staff-patient ratios (1):

> *'As time goes by though you get experience and you trust in your colleagues and so you feel all right.' (SEN 7)*

Those who reported not being scared (three men and one woman) described their feelings as being wary or cautious.

6.9.3 Feelings when patients threaten or hurt staff

Three points emerged from responses of those (15) who discussed feelings when they or colleagues were threatened or hurt by patients: feelings towards individual patients (12): responses to patients (10): and whether violence should be accepted as part of the job (7).

i) Individual patients

All (12) discussed their feelings towards patients whose violence they attributed to mental illness in terms of understanding:

> *'I know that they're sick. My feelings towards them don't change. They must be sick to do some of the things that they do. I've got no hard feelings with any patient. The one that attacked me yesterday, I was cuddling five minutes ago.' (SEN 4)*

Half this group, however, contrasted their feelings for those whose violence they attributed to mental illness and for those whose violence was not so attributable. Referring to the latter group they spoke about feeling angry or cross:

> *'It depends on the patient. If its a bad patient, a naughty patient, sometimes you get cross, knowing that they are doing it on purpose, that they're not really ill. We do get patients coming in here who know jolly well what they are doing and what they are up to.' (SN 7)*

Two interviewees described sometimes feeling angry even when knowing patients were ill:

> *'I get angry of course, but I try to understand because they are not in control of their thoughts - they lose control of their mind I suppose, lose control of their ability to reason, to think, all these psychological factors.' (SN 5)*

ii) Responses to patients

Describing responses to patients, interviewees (10) included: not retaliating in kind (4); defending oneself (3); keeping calm (2); keeping oneself under control (2); cautioning patients strongly if felt that knew what doing (2); and subsequently refusing patients favours, such as extra bread (1). Two observed that nurses should remain controlled and calm but that they were human and sometimes could not help being angry. One remarked that guidelines recommended staff not showing anger and when asked if that was possible replied:

> *'No, we are all human. We just can't go by the book. You do tend to lose your temper sometimes.' (SN 6)*

iii) Part of the job

Views were expressed over whether violence should be accepted as part of the job (7). The CN described his awareness that views varied and that some nurses felt violence was unacceptable. Observing that working on the ward was voluntary, he said that if staff felt unable to cope they could request a transfer. Personally he regarded violence as part of the job:

> *'I enjoy working with aggressive people. I know that the patients can become violent and disturbed and I accept that.' (CN 1)*

Five others held this view, describing violence as an occupational hazard to be tolerated, whereas a sixth was more questioning:

> *'Sometimes I wouldn't deny the fact, you just feel what's going on here, why do I have to take this from them?' (SEN 6)*

6.9.4 Feelings about the work environment

Feelings about the locked ward included perceptions of whether it was stressful (15). Most (13) felt it was, although four qualified their reply by saying that they did not always feel stressed and one that it depended on his attitude on arrival at work. Sources of stress described all related to aspects of violence. Consequences of stress included taking a long time to unwind after work (2) and phoning in to say you were unwell when needing a break (1). The interviewee who made the latter point said this occurred frequently and referred to a recent report that recommended staff having seven annual 'burn-out' days. Such days allowed staff to express the need for respite from a stressful working environment but the present ethos here was such that if staff said they felt too stressed to work, he said that others would regard them as being unable to cope at all.

Positive feelings about the environment (11) included: preferring acute to other settings (3); feeling safe through having appropriate skills (2); and enjoying the work (6). Decreasing enjoyment was attributed to anxiety as a close-knit team was breaking up (1) and to getting older (1).

6.10 RIGHTS AND LEGAL POSITION

Seventeen interviewees discussed aspects of the rights of patients and staff and the legal position of nurses.

6.10.1 Patients' and nurses' rights

In discussing patients' and nurses' rights the following points were raised: situations where clarity about appropriate actions was lacking; nurses being accused of assault: management support for nurses against whom allegations of assault had been made; nurses charging patients who assaulted them; and protection afforded by the Mental Health Acts.

i) Situations lacking clarity

Those who spoke about situations that lacked clarity (12) referred to self-defence and involvement in restraint. Over the former, concern focused on whether nurses could defend themselves if attacked. While two interviewees reported defending themselves at times, another said that even though nurses are sometimes in danger they do not have the right to use self-defence. A fourth observed that the DNS had recently clarified the position by stating that if nurses were attacked when alone, they could use reasonable force in their defence.

ii) Nurses accused of assault

While nurses did their best to ensure that no-one was hurt (5) injuries did sometimes occur in the course of a restraint (6):

> *'When you get in a struggle, you all do get scratches. Sometimes the patient might get scratched in the struggle and the nurse is then in a difficult position.' (SEN 3)*

When patients were hurt, nurses were vulnerable to accusations of assault by patients and/or their relatives (6), although two emphasised their confidence in accounting for their actions. Moreover, patients sometimes accused nurses of assaulting them even when restraint had not occurred (2).

iii) Management support for nurses accused of assault

While the CN reassured staff that they should not feel insecure if acting in good faith. others (9) were concerned that patients' views were favoured when allegations of assault occurred. There was an automatic assumption that nurses were in the wrong (3) and whereas many organisations were concerned with patients' rights (2) there were none to defend nurses (7):

> *'I think there seems to be nothing going for the nurses. Everything is on the patients' side. The nurse seems to have nobody on her side.' (SN 7)*

Vulnerability also lay in whether managers would support nurses accused of assault (11) with most (8) feeling that support would not be forthcoming:

> *'You do the thing that seems right at the time but sometimes it happens that things tend to go wrong. Then you often feel that management is not on your side. The management if they are doing their job have got to take some action, but then if you deep down feel that you have done the right thing, then you really feel that you've been let down.' (SN 1)*

Others (2) were unsure whether support would be forthcoming and another thought it depended on whether managers liked the individual concerned. I did not ask interviewees whether they had been accused of assault since it seemed too sensitive, although two volunteered the information that they had. The CN argued that many more allegations should be quashed and not referred to higher levels for an inquiry.

iv) Nurses charging patients

The NO felt that nurses avoided going to court when assaulted as they thought they would lose; hence a body to support nurses in this event might help overcome this reluctance.

v) Protection afforded by the Mental Health Acts

The majority (12) thought that patients' rights took priority over those of nurses. The perception that this was the case was attributed to changes introduced by the 1983 Mental Health Act (3). The 1959 Act was regarded as providing nurses with protection against allegations of assault whereas the 1983 Act was not:

'Yes, the old mental health act used to back the nurses. Now there is no backing at all. You see anybody can accuse the nurse falsely, and if that nurse can't prove that he is innocent, he is framed under this new act, and that's a sad thing, its a bad day because we don't have any protection at the moment.' (SEN 7)

6.10.2 Effect of concern about legal position

Concerns about nurses' legal position had several adverse effects (8). Most (5) believed that nurses would become unwilling to restrain, although none attributed this to themselves as yet. The CN felt that consequences could be dangerous:

'Now if a nurse feels that way, this is when people are going to be injured. You will get one person trying to defuse the situation, but another, because they're unsure of their legal standing will be afraid to touch the patient.' (CN 1)

Fear of allegations of assault necessitated constant awareness of possible legal consequences of one's actions (3) and this was manifest in contacting nurse managers and doctors for advice far more frequently than hitherto (1). This fear also necessitated being certain that everyone was in agreement over the content of incident reports (2). This vulnerability to accusations of assault had contributed to reluctance over learners being placed in the ward since they might misinterpret situations (4).

Fear of allegations might also result in nurses avoiding restraint even when this was the best course of action (3). The CN argued that managers should resolve uncertainty as to what nurses could do, since uncertainty led to ineffectiveness. The NO also made this point by describing a patient whom staff avoided as her relatives were always accusing them of assault. Another outcome of increasing fear of allegations was adverse effects on retention (2):

'They are afraid of litigation. You're finding that a lot of staff are leaving because of this.' (CN 1)

6.11 OVERVIEW

This chapter has provided a detailed account of the views and experiences in relation to violence of nursing staff working in an acute, intensive care, locked ward. This was the setting in which incidents were most likely to occur; all interviewees had been involved

in incidents and most had experienced being assaulted. Most admitted to feeling scared on occasion. This final section draws together key findings including interviewees' perceptions of factors that had a positive impact on the ways in which they were able to relate to violence and those that had a negative impact.

Positive factors included their own skills and experience in preventing and managing incidents and being confident in decisions when in charge. Being a long-standing team was viewed positively, especially in situations when patients were restrained. Other positive factors included medical staff coming when requested to review patients, nurse managers sending extra staff when requested in emergencies, having confidence in these staff, and benefiting from discussing incidents.

Factors that were perceived as impacting negatively on capacity to cope with violence included: medical staff admitting patients when resources were inadequate; medical staff not providing patients with adequate information; the size and layout of the ward; lack of certain resources; insufficient staff; and use of agency staff. Views about learners having placements on the ward differed but there was concern that they had insufficient experience of acute care settings.

Many felt that patients' rights took precedence over those of staff and that support from nurse managers would not be forthcoming for staff involved in incidents. A distinction was drawn between feeling angry with patients perceived as knowingly assaulting staff, and not feeling angry with patients perceived as assaulting staff because of their illness. Several differences of view emerged; these included the degree of pre-planning that took place prior to managing an incident, whether post-incident discussions were held and whether medical staff took account of nurses' opinions about treatment.

CHAPTER 7: VIOLENCE IN CONTINUING CARE SETTINGS

Two settings were selected for adult continuing care services, one designated as a medium-stay ward (Sections 7.1 to 7.10) and the other as a long-stay ward (Sections 7.11 to 7.20).

7.1 MEDIUM-STAY: PROFILE OF INTERVIEWEES

On the medium-stay ward, eight of the eleven staff were interviewed: the two charge nurses (CN); four of the five staff nurses (SN); and two of the four enrolled nurses. Nursing auxiliaries were not employed on the ward. Interviewees were evenly drawn from the two day-duty shifts (5) and the night-duty shift (3). There were four men and four women from a range of ethnic groups, with an age range from early 20s to late 50s. Time since qualification ranged from one to 20 years and all but one had worked on the ward for two years or more. The nursing officer (NO) was a white woman in her mid 40s who had been qualified for 17 years.

7.2 MEDIUM-STAY: THE SETTING

All interviewees provided information about the setting.

7.2.1 Patients and programme

Patients designated as medium-stay were admitted to this mixed sex 30-bed ward from the locked ward or the other admission ward. According to most staff (7), patients' diagnoses included schizophrenia, depression, manic depression and substance misuse. Although most patients were informal admissions, some were admitted under a section of the 1983 Mental Health Act. Length of stay varied between three weeks and three months. As part of the programme of ward closures and relocation, a group of long-stay women patients had recently been admitted. One CN said that this group mainly suffered from behavioural disturbances that he attributed to having spent many years in hospital. Plans were to prepare these patients for transfer to community settings but in the meantime there was less scope for admitting other patients requiring medium-term care.

Aims of the programme were described as helping recovery from mental illness and rehabilitation in preparation for discharge to the community. particularly for the longer-stay patients. Components of the programme included ward-based activities, medication, sessions in occupational and recreational therapy departments and discussions with nursing and medical staff. The ward comprised a communal day room and dining area and separate sex sleeping and bathroom facilities.

7.2.2 Nurse staffing levels

The allocated day-duty staffing level was three qualified staff (CN, SN and SEN) and one or two students. Sick leave and annual leave meant that frequently only two qualified staff were on duty. Interviewees' assessment of adequacy of staffing levels related to explanations for incidents (Section 7.5.4.iii)) and their management (Section 7.6.2 ii)).

Occasionally three staff were on duty at night but usually it was two (two SNs or an SN and an SEN). One interviewee said two staff was sufficient whereas two felt more were needed. All three commented that extra help could be summoned if necessary. Just one of the four night-duty staff was male and, consequently, was always on duty with a woman. He spoke at length about the difficulties this posed in relation to managing incidents (Section 7.6.2). When he was off duty, a male nurse from another ward was allocated to the shift so that there was always one man present.

The NO thought that there were insufficient staff on each shift to provide the programme of care and regarded it as the District Health Authority's responsibility to recruit more staff. Two of the day shift interviewees said that members of the three shifts got on well and one night-duty interviewee described good relationships with day staff.

7.2.3 Medical staff and nurse managers

i) Medical staff

Five consultants had responsibility for patients; a situation regarded as disruptive of the ward programme through too many doctors' rounds (2). All day-duty interviewees discussed working relationships between nursing and medical staff. The topic was not

pursued with night-duty interviewees since they said they rarely had contact with doctors.

Very diverse views emerged. The CN and SN on the day-duty A shift both felt that most medical staff did not respect their views. The SN was particularly vehement about the topic:

> *'Doctors listen to everyone's views - psychologists, social workers, nurses - but take on board everyone's view <u>except</u> nurses. Yet we are the ones with patients twenty four hours a day and probably know them better than anyone.' (SN7)*

In relation to incidents, this was manifest in not accepting nurses' views on the causes of incidents and their appropriate management. A completely different view was offered by the A shift SEN and the two B shift interviewees. They reported doctors as being supportive of and listening to nurses generally and in relation to violence. The B shift SEN felt that certain decisions, such as which patients should be admitted to the ward, were doctors' responsibility and not one in which nurses should be involved. For the NO, the problem was one of medical staff spending insufficient time in the ward to develop a multidisciplinary approach to care.

ii) Nurse managers

Working relationships between nursing staff on the ward and nurse managers were explored with all interviewees and positive and negative comments were made. The three day-duty A shift interviewees said that managers rarely visited the ward and had little involvement in ward life though all felt that they should be more involved. The CN felt that they would have much to contribute, given their clinical experience. The two day-duty B shift interviewees had opposing views, with one saying involvement was not sufficient and the other that the NO:

> *'is good and will always sit down and discuss things.' (SEN 11)*

Differing views were also expressed by night-duty interviewees. The male SN described support as mixed, one of the women said that it was good and the other that it was not.

7.2.4 Suitability for admission

Interviewees (6) questioned suitability for admission of several groups of patients. Patients with personality disorders were said (3) to be not mentally ill (2) and not suitable for psychiatric care (1). There should be better assessment of patients so those with personality disorders could be identified (2) and referred to a secure unit (1) or to prison (1). These patients featured prominently in accounts of incidents and a CN described them as a threat to the health and safety of other patients. He described trying to persuade such patients that their behaviour was unacceptable and that they should discharge themselves but added that if such patients refused to leave there was nothing nurses could do since they did not have the power of discharge. Three such patients recently resident on the ward had all been transferred to the locked ward and a fourth who had been discharged had recently returned threatening to attack female staff.

Some patients with neurotic conditions were regarded as unsuitable since their problems lay in family relationships that remained unchanged upon discharge (1). Some of the long-stay patients were regarded as too disturbed for the ward whereas others were ready for discharge but rehabilitation hostel or community places were unavailable (2). Moreover, some had become more disturbed since being relocated to this ward (1). The NO referred to two groups as inappropriate for the ward: those whom she felt should be in a secure unit and those waiting for a place in the community. She described difficulties caused by lack of support from medical staff and senior nurse management in decision-making about the placement of patients who were violent. This lack sometimes left her and the locked ward NO to argue about the best place for particular patients whereas she thought that someone at a more senior level should make the decision. She had raised the matter with the Assistant Director of Nursing Services but had not had a response as yet. The locked ward NO, however, made no reference to such problems.

7.3 MEDIUM-STAY: DEFINITIONS AND INCIDENCE

Six of the eight interviewees defined aggression and violence. Three said they used the terms interchangeably to refer to physical or verbal attacks on others. A fourth interviewee said aggression was less strong than violence and another spoke about verbal aggression as distinct from physical aggression and that he used the latter term

rather than violence when physical contact was made. The sixth said his definitions varied by patient, since behaviour he would regard as aggressive for one patient would not be thus regarded for another. The NO made a distinction between violence as inflicting physical harm and aggression as verbal abuse.

All described the manifestation and frequency of incidents. Manifestations ranged from verbal abuse (including racial abuse), threatening behaviour (including threatening with objects), breaking objects, kicking doors, throwing furniture and slapping, punching and kicking others. Statements about the frequency of verbal abuse and threatening behaviours varied. Some said verbal abuse was constant, others that there were quiet periods and disturbed periods on the ward. Some said threatening behaviours occurred everyday, others said once or twice a week. Incidents involving a physical attack on another occurred intermittently and recollections of recent such incidents included one two days ago, one three months ago and one six months ago. All had been involved in incidents on the ward and three recounted being hit. The NO thought that there was less violence than previously but the nature of incidents was more serious with staff being hit rather than windows being broken. The night-duty SNO commented that nasty incidents could develop very quickly on this ward.

7.4 MEDIUM-STAY: SOURCES OF GUIDANCE

All interviewees discussed sources of guidance.

7.4.1 Education and experience

While all (8) said that the subject of violence had been included in their first-level course, comments (4) on adequacy of preparation were more likely to be negative (3) than positive (1). One interviewee reported that participation in handling incidents during a year's placement had prepared him, not school-based sessions.

Just one of those with whom post-basic education was discussed (7) had attended a session on violence: an in-service course to prepare staff for working on the locked ward. Of the others, four said that courses on violence were needed. One observed that such need was evident in that whenever she attended a course, whatever the subject, the discussion usually ended up focusing on violence. Other points made were that staff

needed opportunities to share experience about managing incidents and to learn how to restrain. One CN said that the focus of the current continuing education programme was inappropriate:

> *'They keep sending us on fire lectures, and us getting beaten up nearly every day and nothing happens.' (CN 2)*

Night-duty interviewees described difficulties in attending courses held during the day and one argued that ward-based updating sessions should be held at night. The NO thought staff needed more courses on violence than currently available and that provision of refresher courses was also important.

Of those who described how they had learnt about preventing and managing violence (5), all reported learning from experience, either during student placements (1) and/or as a qualified nurse (5).

> *'And from being involved in situations yourself and if you solve something successfully and prevent an aggressive outburst, then you sort of feel satisfied and go out and think that went OK, I'll try that the next time.' (SN 8)*

Two commented that experience had been of far more value than school-based sessions. The NO remarked that while observation and communication skills could be taught, there was no substitute for experience.

7.4.2 Guidelines

Of those with whom guidelines were discussed (7), three said that they were available on the ward, three that they did not know whether they were available and one thought so but was unsure. The NO, however, said that the guidelines were included as a policy in the procedure book and that all new staff were informed about this book. Those who said guidelines were available were asked if the document was helpful and those who were uncertain about availability were asked whether they thought that written guidelines would be helpful. Six answered in similar vein: namely that when preventing and/or managing incidents, they drew on their experience rather than follow guidelines. Emphasis was placed on using individual judgement:

> *'When an incident happens you can't use a particular technique, you have to do what seems right.' (SEN 12)*

and knowledge of patients:

> *'They [guidelines] don't help, it's a question of knowing your patients and how to approach them.' (SN 11)*

One interviewee thought that guidelines should be available for students and the most recently qualified interviewee reported finding guidelines useful in that they described alternative approaches to handling incidents. According to the NO, the Assistant Director of Nursing Services and a consultant with a particular interest in the subject had devised the current guidelines. Two interviewees commented that ward staff should have had input into the development of the guidelines.

7.4.3 Discussions with colleagues

Interviewees (7) described their discussions about the causes, prevention and management of violence. A difference emerged between the day shifts. Staff on the A shift knew each other's views and acknowledged that they differed over causes of violence. The CN saw some violence as a means of communication for people who felt unable to convey their point of view. Others regarded everyone as innately aggressive and thought that when aggression could not be appropriately channelled it was manifested as violence. The A shift interviewees, however, all said that they discussed violence constructively so that although views about causes might differ, policies about prevention and, particularly, management were consistent:

> *'When we have a violent patient, we always sit and discuss and have a long talk about it - so everybody has the same views as what to do when an incident occurs.' (SEN 11)*

The B shift interviewees both said that they thought other staff held different views from themselves about causes of violence but did not know what they were. Nonetheless, like the A shift, they reported that regular discussion meant consistent policies were adopted over prevention and management.

Night-duty interviewees said (2) that discussions about violence took the form of informal conversations while working together and during handover to the day staff and

if night staff made recommendations concerning, for example, different medication for a patient who was more disturbed than usual, day staff always took it up with medical staff.

7.5 MEDIUM STAY: EXPLAINING AND PREVENTING VIOLENCE

Explaining and preventing incidents were discussed with all eight interviewees.

7.5.1 Patient attributes

All interviewees referred to mental illness, either generally with phrases such as 'being sick', or because of specific conditions: psychosis, hallucinations, paranoid delusions and hearing voices. A distinction was made between being 'mad' and being 'bad' (5). Some patients were regarded as knowing what they were doing when attacking nurses or other patients. In this context specific reference was made to patients diagnosed as psychopathic (2). As a CN put it:

> *'Unfortunately, I think there's also a certain amount of aggression that's purely criminal and psychopathic.' (CN 3)*

The other CN said that medical staff attributed all violence to mental illness. He found this frustrating when, as a nurse, he felt that patients were behaving badly but were not confronted about it because medical staff attributed their behaviour entirely to mental illness.

7.5.2 Structural environment

The NO described the dining room as very cramped and thought that irritation caused by close proximity led to plates being thrown. The only other observation made was a night-duty female nurse who said that she always made sure the kitchen was locked, since she felt a patient could slip in unnoticed and take a knife.

7.5.3 Interpersonal environment

All described aspects of the interpersonal environment.

i) Ward climate

Although the three shifts got on well there were problems over maintaining consistent approaches to patient management. This contributed to incidents (2) since. if patients were allowed to act in one way by staff on one shift but not by staff on the other, they became angry with the latter. Moreover, some patients knew that staff on one shift would be more likely to tolerate certain behaviour than staff on another and so acted accordingly. An SN who felt particularly strongly about having consistent management policies felt there should be a forum for permanent staff to discuss policies. A CN reported, however, that although there was a regular unit meeting it did not cover the topic of patient management and that ward staff had just as much responsibility for undertaking such discussions as nurse managers.

ii) Nurse-patient relationships

Good communication between nurses and patients was described as the most important factor (2). Another observed that gaining patients' trust meant they would know nurses would not hurt them so they would not hurt nurses. Although two felt that nurse-patient relationships could be a factor in violence, provocation by nurses was unintentional. The NO commented that she had often seen staff talk to patients in a way that made them angry and attributed this behaviour to pressures of being understaffed and demands made on their time by medical staff. One interviewee remarked that black patients felt particularly angry with black nurses who they felt should be on their side, meeting their demands.

7.5.4 Programme of care

i) Medication

Patients whose medication had been reduced because they seemed much better quite often showed signs of becoming disturbed again and so it was important to increase the dose before an incident occurred (1).

ii) Activities

Emphasis was placed on keeping patients occupied since boredom caused by lack of activity was said to be a cause of incidents (5). A CN described opportunities for patients to attend therapy departments as 'appalling' since the range of facilities had been reduced and the attendance policy had become so selective that the majority of

patients were excluded. Consequently many patients were based on the ward all day and both CNs said that lack of material for ward-based activities meant that they were often unoccupied. One added that if, for example, he wanted patients to have the experience of cooking, he had to pay for ingredients himself. At present there was no input from occupational therapists to provide ward-based activities (1). The NO expressed concern about lack of activities and occupational therapy facilities, particularly for the long-stay patients.

Whereas some patients enjoyed therapy sessions, others made excuses not to attend (2), with some becoming angry when staff insisted they did so (1). Two day-duty interviewees felt that patients should comply with the treatment programme or else be discharged:

> *'Some of them are not prepared to do anything and lie in bed all day. When you try to explain to them that they are not achieving anything and should attend a department, they become verbally abusive.' (SN 8)*

iii) Staffing levels

Staffing levels were regarded as insufficient for nursing staff to implement the full programme of ward activities; this meant that patients became bored and for some this was identified as a cause of incidents (4). Certain patients were abusive to staff when aware that staffing levels were low (2). The NO added that insufficient staff meant that signs of incidents developing were not always noticed. A female night-duty interviewee commented that having a male nurse on duty helped prevent violence. His presence helped give patients a sense of security and:

> *'stopped them playing the fool unless they were really mad'. (SN 11)*

iv) Access to medical staff and information

If patients were unable to see their doctor at the time of their choosing, they sometimes became aggressive towards nurses (1). The NO was concerned about instances when medical staff did not allow enough time with patients to explain changes in treatment such as reduction in medication since they subsequently became upset and angry with nursing staff. Information about violence in patients' histories and in events since admission was available in various written formats. Three interviewees made positive comments about this documentation and said that they felt well informed on the subject.

One CN said that while nursing staff needed to know whether patients had a history of violence for safety reasons, this knowledge meant that they might act in a way that signalled to patients that violence was expected. This, in turn, might increase the likelihood of a violent response.

7.5.5 Aspects of daily life

Several aspects of daily living were identified (8). Patients became aggressive when staff could not respond to their demands for more cigarettes (3). when not allowed to take food from the kitchen whenever they wanted (1) and when urged to go to bed when they wanted to watch late night television (the interviewee who made this point felt that much violence was attributable to lack of sleep). Although informally detained patients were entitled to leave, staff were concerned about their safety if out at night (2). The approach adopted was to explain to patients why it was preferable that they did not leave the ward although some became aggressive in response (2). When patients insisted on leaving, the policy was either to request from medical staff a Section 5 (Detention of patients already in hospital) in order to prevent them leaving, or ask them to sign a discharge form. Other causes of incidents included sexual frustration since sexual activity was not allowed on the ward for fear of allegations of rape (1), and tensions between West Indian and Asian patients (1).

7.5.6 Knowing and observing patients

Knowing patients well meant that nurses could judge when to approach them and when to leave them alone (4). Careful observation of patients' moods and behaviour facilitated recognition of signs that an outburst was imminent and enabled preventative action to be taken (2).

7.6 MEDIUM-STAY: MANAGING VIOLENCE

All interviewees discussed managing incidents.

7.6.1 Primary management

Responses defined as primary management (6) included interpersonal skills, letting aggression run its course and reviewing medication. Good interpersonal skills were important since it was often possible to calm patients down by encouraging them to talk

things over (3). Another approach was offering patients a hot drink and cigarette (1). On occasions, however. the best approach was to let aggression run its course (2). Thus when patients were screaming and shouting but not hurting anyone else, they were sometimes left to 'get it out of their system'.

Benefits of medication in calming patients down were identified (4) although two added that since patients were informally detained they were within their rights to refuse medication. Examples were given of patients who had been persuaded to take medication, although initially reluctant to do so, whose relatives had subsequently complained. Interviewees on the A shift who were critical of relationships with medical staff spoke of hoping that they would accept nurses' recommendations for reviewing medication.

7.6.2 Secondary management

The responses of interviewees (8) allocated to secondary management concerned decision-making, staffing and summoning help, and methods used.

i) Decision-making

Six interviewees discussed decision-making. One CN described his decisions to adopt a more interventionist approach in terms of how he was perceived by other staff:

> *'In a job like this, if you let things [incidents] go on, other nurses will say you have gone soft. Others say you have to put your foot down, show them who is the master, who is running the ward. To prevent injury to other patients you have to draw the line.' (CN 2)*

While one (an SEN on the A shift) said that the nurse in charge made the decision, others reported a less structured approach. Thus, the two B shift interviewees said the person nearest to the incident started dealing with it and then others assisted. The two A shift interviewees and the night-duty interviewee described staff as acting instinctively and quickly, since delay while plans were formulated might result in injury. In the words of the A shift CN:

> *'One or two of the staff here are very well controlled, very well experienced with violence. Obviously we know each other well, we've worked together, there often isn't a need to say much.' (CN 3)*

These two A shift interviewees said it was unrealistic to formulate a plan before taking action but, nonetheless, added that new staff and students should be given explicit instructions as to what they should do. The perspective offered by the NO was that the CN made the decision as to how incidents should be managed and that she would only be informed if he requested more staff.

ii) Staffing and summoning help

a) Adequacy. Day-duty staff usually attempted restraint without requesting extra staff but said that help from other wards could be summoned quickly when necessary (5). Night-duty staff, however, summoned help first since only two nurses were on duty (2). The male night-duty interviewee said that an alarm button should be installed in the office since if a patient cornered a nurse there and the other staff member was not in earshot, there was no-one to ring the alarm in the corridor.

b) Support. Day-duty interviewees felt well supported by each other. The SN added that if a male patient was behaving violently, then it was his responsibility, as a man, to deal with the situation in the first instance, though female staff might subsequently assist. The night-duty male interviewee reported feeling vulnerable as he was always the only man on duty. In his view, female staff were reluctant and scared to get involved in dealing with incidents and expected him to cope with them, even when female patients only were involved. His preference was to have another man on duty in addition to himself and the female nurse but at present he had to obtain help from other wards for any incident with which he could not cope alone. Although he had conveyed his views to nursing management nothing had changed and he commented that their concern was with numbers per shift, rather than appropriateness of the staff mix for the patient population. One of the female interviewees, however, said that she could, and did, deal with problems with female patients but needed help with men. All eight interviewees said they could always rely on support from staff summoned from other wards to assist.

iii) Methods of management

When patients became physically aggressive towards others or were damaging property, staff applied restraint. In most instances this was followed by medication (5). The A shift CN said that although violence in the short-term was usually managed by

medication he was unsure that this was good practice. When restraint and/or medication failed to calm patients down. staff requested that they be transferred to the locked ward for a while and the A shift interviewees spoke of hoping that medical staff would accept their recommendations in this respect. The night-duty NO described an incident on this ward when he had been asked to send extra staff. Subsequently one of the female staff present that night said none of those on duty knew how to restrain.

All eight interviewees discussed the role of the locked ward. All felt that the facility was necessary, with one adding that a second was needed. The security provided was essential for patients posing a danger to other patients, as well as to themselves (3). One CN observed that if the hospital adopted a policy of only admitting patients who were genuinely mentally ill and excluded those with personality disorders, a locked ward would not be needed. Moreover, he said it would be possible to manage without a locked ward if there were more staff on open wards, a point with which the NO concurred. The latter added that while it was preferable for patients to remain on their own ward this was not possible when only one man was on duty.

Three interviewees considered the effect of the locked ward on nursing skills. One maintained it had none since staff managed disturbed patients on open wards until it became impossible and the locked ward was used as a last resort. A contrasting view was offered by a CN who said that nurses did not use all their skills in managing patients because they regarded locked ward staff as able to manage them better. He added that were the locked ward to be closed, nurses would have to use other approaches such as special observation and medication. The other CN said he hoped I would not ask him whether there should be a locked ward because he did not know. On one hand the patient population required such a facility, yet:

> *'I sometimes feel it is a failure on my part to send a patient to [the locked ward] and that if it didn't exist then I would try harder and other nursing staff would try harder.' (CN 3)*

7.7 MEDIUM-STAY: POST-INCIDENT EVENTS

Six interviewees discussed post incident events.

7.7.1 Recording incidents

Varying views emerged when interviewees (5) discussed which incidents merited recording in the incident book. The A shift interviewees said that they recorded incidents of seriously threatening behaviour as well as those involving physical attack. The SN and SEN also commented that whether patients' actions were recorded as violent incidents depended on staff's knowledge of preceding events. The CN observed that on the A shift, staff recorded incidents in which injury had been a possibility and contrasted this to other nurses who only recorded incidents in which injuries had been sustained. This latter position was the one reported by the two B shift interviewees, although one added that verbal aggression would be recorded in patients' notes.

7.7.2 Discussing incidents

Day-duty interviewees all said that staff discussed incidents, focusing on whether they could have been prevented and how staff had responded. All found these discussions helpful and two added that students should be included. Nurses discussed incidents with patients involved (3) although some felt that patients either resisted discussion or did not take discussion seriously (2). While the NO was usually informed about incidents, the A shift CN said she was not usually involved in post-incident discussions since ward staff handled the matter themselves. The SEN on this shift expressed the view that the NO should be involved. The NO also thought it important for managers to be involved and, in contrast to the CN's comments, said she tried to visit the ward as soon as possible to talk through events, especially with junior staff. At one time there had been a unit meeting for night staff but this had been discontinued. The male SN said that this meeting had included useful discussions about violent incidents.

7.7.3 Post-incident support

While interviewees said most managers were supportive of staff involved in incidents, two made negative observations. A CN said that managers always criticised the way nurses had managed incidents. A night-duty interviewee said she always felt under pressure not to take any sick leave after being hurt, since nursing management held this against staff subsequently.

7.8 MEDIUM-STAY: LEARNER NURSE PLACEMENTS

The ward was included in the teaching circuit for both psychiatric and general nurse learners. Previously placements had included night-duty experience but they were now confined to day-duty only. Most (7) expressed views about placements.

7.8.1 Placements on the continuing care ward

Views expressed included: learners should be involved in handling incidents in their final year if they felt capable of doing so (2); learners should not be involved in restraint (1) and should always be involved in post-incident discussions (1). The NO stressed the importance of learners observing how the CN and other trained staff dealt with incidents. Concerns emerged (2) that, on occasion, learners had been unhappy with the way in which incidents involving restraint had been managed and had voiced criticisms to tutorial staff. In some cases tutors had subsequently complained about ward staff to nursing managers, whereas interviewees felt that learners should first have discussed their views with ward staff.

All day-duty interviewees (5) said that they had no awareness of content of school-based sessions since there was little contact between tutorial and ward staff. One CN said that while he was uncertain what students were taught, it was likely to be in line with tutors' focus on communication skills, and that tutors attributed violence to lack of communication by nurses. In his view, there was too much concentration on developing skills through role-play and group work but little development of a knowledge base.

7.8.2 Placements on the locked ward

All felt learners should have a locked ward placement with one adding that this should be in their final year, a view also held by the NO. Without such a placement some learners could complete their course having seen few, if any, incidents (2). Although incidents did occur on open wards, a placement could coincide with a quiet period. Most interviewees had said that their own confidence in coping with violence had come from experience (5) and the fact that many learners were qualifying without this experience caused concern as to how they would cope once qualified (2):

'If students don't have this experience then when they are a staff nurse, when they're in charge of the ward and there's an aggressive outburst, they haven't a clue what to do.' (SN 8)

7.9 MEDIUM-STAY: FEELINGS ABOUT VIOLENCE

Six interviewees discussed their feelings about violence.

7.9.1 Feeling scared

Four interviewees reported feeling scared on occasion. Causes of fear included patients threatening to kill nursing staff or to get friends from outside to do so, new patients not known to staff, and staff having to cope with incidents unaided. The last point was made by the night-duty male SN who had already voiced his concerns that female staff avoided involvement in handling incidents. Two interviewees reported never feeling scared and both attributed this to the confidence that came from experience. One added that this confidence came from locked ward experience and describing patients on this ward said:

'This is nothing to me, this is small fry.' (SEN 11)

7.9.2 Feelings when patients threaten staff

While five interviewees said they accepted violence from patients, four stressed that their feelings depended on whether or not violence resulted from mental illness. In cases when patients were judged to be genuinely mentally ill, interviewees were able to accept being physically attacked:

'I can accept aggression from them because it is not intentional, maybe they are responding to hallucinations. I have been hit a few times by psychotically ill patients and I don't mind - I don't feel angry.' (SN 8)

They did not, however, have the same acceptance of violence from patients who, in their view, were not mentally ill:

'But when you know someone is being unpleasant for the sake of it, the enjoyment of it - it's frustrating. We shouldn't have to take it as part of the job.' (CN 3)

Nurses from ethnic minority groups, asked how they felt about verbal racial abuse (3). expressed differing views. The two women said that it did not bother them and that they experienced it outside the hospital as well as within:

> *'It's just one of those things, words. And you accept it, I mean you hear it outside, so why not hear it from your patients. It never bothered me, I just accept it.' (SEN 12)*

The man, however, said that racial abuse offended him and that he confronted patients about such behaviour.

7.10 MEDIUM STAY: RIGHTS AND LEGAL POSITION

All interviewees (8) discussed aspects of patients' and nurses' rights and the legal position of nurses.

7.10.1 Balancing patients' and nurses' rights

Several points were raised in interviewees' discussions about patients' and nurses' rights.

i) Situations lacking clarity

Noting that the guidelines stated that if nurses use minimum force during restraint their actions would be supported by management, two interviewees expressed concern about what constituted minimum force. In their view, the degree of force required varied by patient and nature of the incident.

ii) Nurses accused of assault

Four interviewees drew a distinction between being legally covered to some extent when restraining sectioned patients and not being covered at all with patients who were informally detained. If patients in the latter category were bruised during restraint, it was said that nurses could be sued and had no legal protection.

iii) Support for nurses accused of assault

Four interviewees expressed the view that the balance of rights favoured patients. Three of these observed that this was made manifest by nurse managers always believing

patients rather than nurses when accounts of incidents differed. The fourth commented that much publicity was generated if a nurse hit a patient but none when the reverse occurred. Four interviewees commented that the 1983 Mental Health Act did not protect nurses involved in incidents.

iv) Nurses charging patients

The NO said she would like to see charges brought against informally detained patients who injured nurses since the lack of sanctions meant that violence recurred. Although it was acknowledged that nurses could sue patients this rarely, if ever, happened in interviewees' experience (2). According to the A shift CN this was because medical staff attributed all violence to mental illness and would always sign a form to this effect. This meant that patients who attacked nurses could not be held responsible for their actions and so there was little point in pressing charges against them.

7.10.2 Effects of concerns about legal position

A night-duty interviewee said that concern about nurses' legal position meant that great care had to be taken when writing statements about incidents since:

> *'you do not know what they are looking for'. (SN 10)*

She commented that previously she and others had sought help from a solicitor when constructing accounts of incidents.

7.11 LONG STAY: PROFILE OF INTERVIEWEES

All five staff on the long-stay ward were men and all were interviewed. Two worked on the day-duty A shift (a CN and an NA), two on the day-duty B shift (an SN and an NA) and one on the night-duty shift (an SEN). Three were in their 30s, two in their 50s and they encompassed a diverse range of ethnic groups. The CN and SN had been qualified for 14 years. The SEN had started work as an NA 20 years ago and had gained an enrolled nurse qualification on the basis of this experience. The two NAs had two and three years experience respectively. Some questions, such as those on definitions and education, were explored in a somewhat patchy manner with these interviewees. They appeared particularly nervous about the subject and it was difficult to maintain the

rapport necessary to overcome this since interviews were frequently interrupted as, with only two staff on duty, interviewees were called away for periods of time. The NO, a white man in his early 40s, had been qualified for 16 years and most of his experience had been in acute settings.

7.12 LONG-STAY: THE SETTING

All provided information about the setting.

7.12.1 Patients and programme

The ward was for long-stay male patients. Described by qualified staff as 'chronic', primarily schizophrenic and very disturbed, only a few were regarded as violent. The programme of care aimed to provide a range of rehabilitative activities in preparation for discharge to community settings. Activities described included playing games, watching television and discussions with nursing staff. The ward comprised a day room that included a dining area, a dormitory, bathroom facilities, two side rooms and the nurses' office. Length of hospital stay of the 19 patients currently resident ranged from three to 27 years.

7.12.2 Nurse staffing levels

The day-duty shifts were each staffed by a qualified nurse and an NA. All four day-duty interviewees said that two staff per shift was inadequate and this affected the programme of care (Section 7.15.4) and the management of incidents (Section 7.16.2). While the CN said he had been asking for more staff for years he did not blame nursing management since they were doing their best. The night-duty interviewee was usually on duty alone. An additional member of staff was occasionally allocated to the shift but the interviewee preferred being alone since he felt responsible for the safety of the other nurse, particularly if a woman. The night-duty NO said that patients on the ward were often up at night and could be very difficult, while the night-duty SNO thought that with only one person on duty the ward should be visited more often.

7.12.3 Medical staff and nurse managers

i) Medical staff

The two day-duty, qualified staff held differing perspectives on relationships with medical staff. The CN regarded them as cooperative in that they met regularly with him to discuss patients and review their medication and would listen to his requests for patients to be transferred to the locked ward. The SN, however, said consultants rarely came to the ward and he felt they took the view that so little could be achieved for these patients that there was no point in bothering with them.

ii) Nurse managers

Diverse views were held about relationships with nurse managers. The day-duty CN said they were supportive, referring in particular to attempts, albeit unsuccessful, to recruit more staff. He also said he would appreciate more frequent visits from nurse managers since, as the only qualified person on duty, he felt he needed more support. The SN's response was one of criticism of a management decision to move patients without discussion with ward staff (Section 7.12.4). The night-duty interviewee commented that night managers were supportive if an incident occurred.

7.12.4 Suitability for admission

As part of preparing patients for transfer to community settings, nine patients had been transferred from the ward to a rehabilitation unit on the hospital site. The CN and SN had opposed this transfer as they felt that these patients were not yet ready for this move. Subsequently, nine patients from a long-stay ward for very disturbed patients that was being closed were admitted to this ward so that the population now contained a much higher proportion of disturbed patients.

The qualified staff had differing views on patients' appropriateness for the ward in terms of violence. For the CN none of the patients were too difficult but there was insufficient staff to cope with certain situations. The SN said that the problem lay in having too high a proportion of disturbed patients on the ward who tended to provoke each other, making it difficult for nurses to undertake rehabilitative activities. The SEN, however, felt the situation had improved. The ward only cared for adult patients whereas previously the population had been a mixture of under and over 65s and the

older men had often been hurt when younger individuals had been fighting with each other.

7.13 LONG-STAY: DEFINITIONS AND INCIDENCE

The one qualified interviewee who offered definitions regarded violence as a physical attack, or threat of such with a dangerous instrument and aggression as threatening behaviour. The day-duty qualified interviewees differed over frequency of incidents. The CN said that they occurred daily whereas the SN reported a lesser frequency. I was unable to conclude whether this reflected differing levels on the two shifts or different definitions of what constituted an incident. The NAs described the frequency as variable. The night-duty interviewee reported few incidents at night and thought these were much more common during the day.

Actions described as incidents included shouting, breaking windows, throwing chairs, fighting with other patients and hitting staff. Manifestation varied by patient; for example, one patient was said to break windows, whereas others were more likely to hit each other. Both NAs said that patients were more likely to attack each other than staff. The A shift CN and the B shift NA commented that incidents occurred very suddenly:

> *'It's not something that's been boiling up - it's very sudden - just a "yes" or a "no" can precipitate verbal abuse or physical violence.' (CN 4)*

The SN and an NA had been hit whilst working on the ward and the other three had witnessed incidents in which staff had been attacked. The CN observed that he was less likely to be hit than other staff since much of his time was spent in the office dealing with administration. The NO described the ward as potentially more violent than the locked ward, describing the day before his interview as 'absolutely desperate'.

7.14 LONG-STAY: SOURCES OF GUIDANCE

7.14.1 Education and experience

The SN said that his course had included lectures about violence but that once qualified, he felt much of what had been recommended was unrealistic; for example, advocating

calming a patient through talking when this was often a waste of time and an injection was needed. The CN did not refer to his own first level education and the night-duty SEN had gained his qualification on the basis of experience as an NA. One of the two NAs had been on an induction course but the topic of violence had not been covered. The CN and SN commented that there were few post-basic opportunities on any subject.

Experience was the key factor in learning about violence for this group of interviewees. The SN described learning from practical experience once qualified. The SEN said he had learnt from experience as did both NAs. One NA added that he had also learnt from a relative who was a nurse and by being taught by qualified staff on the ward. Neither NA wanted training on the subject on the grounds that learning from experience was best.

7.14.2 Guidelines

Qualified day-duty interviewees said that hospital guidelines existed. The CN felt that the detailed instructions given might not apply to particular situations facing staff and they had to take action as they thought appropriate. The night-duty interviewee, however, said guidelines were not available, although recollecting a leaflet on the subject being sent to the ward from time to time.

7.14.3 Discussions with colleagues

As there was only one qualified nurse on duty the only opportunity to discuss violence with other qualified staff was at handover (3). The SN said that although he got on well with NAs, not having other qualified staff with whom to discuss patient care, including violence, meant the working environment lacked stimulation. Different perspectives were offered by the two NAs. The one who usually worked on the same shift as the SN said they worked as a team and that the latter had helped him to learn about preventing and managing violence. The other NA usually worked with the CN and was critical of their relationship for not responding to his suggestions about ways of reducing violence (Section 7.15.4).

7.15 LONG-STAY: EXPLAINING AND PREVENTING VIOLENCE

Explaining and preventing violence were explored with all interviewees.

7.15.1 Patient attributes

All (5) said that mental illness was a factor in explaining aggression and violence, accounting for 50% according to the CN, less than half according to the SN and 'a lot' according to the SEN. Reference was made to: hallucinations (3); paranoia (2); delusions (2); hypersensitivity (1); confusion (1), and 'inadequate personality' (1). The SN explained in detail how patients who were paranoid or deluded believed that other patients were laughing at them and hit them in response. These interviewees did not refer to any patients as 'being bad'.

7.15.2 Structural environment

The night-duty NO described this ward as having been very barren until recent attempts to make it more homely. He thought that patients with what he described as 'any inkling of intelligence at all' became violent in response to feeling that they were in a desperate situation because of the lack of any home comforts.

7.15.3 Interpersonal environment

All described aspects of the interpersonal environment. Interviewees spoke about being on good terms with patients and willing to have a laugh with them (2) and ready to discuss their problems (2). The SN observed that although patients were mentally ill some of their thought processes were intact and they knew whether or not they were being treated well. Trying to understand how patients felt was also mentioned (1). Although none of this group thought that nurse-patient relationships caused or contributed to incidents, one added that patients were more 'trouble' when strange nurses were on duty.

The different ethnic groups represented among patients and staff was said not to be a factor in incidents (3). One interviewee commented that patients were such a difficult group that an all male staff was necessary and another that two patients disliked women and became very verbally abusive on occasions when a female nurse was allocated to the night shift.

7.15.4 Programme of care

i) Activities

Day-duty interviewees felt staffing was insufficient to provide a programme of rehabilitation activities and patients became bored (3):

> *'Maybe one of the causes of violence is that the patients, they've all got this energy and yet there's nothing. My opinion is that playing dominoes and that is a waste of time. You've always got to keep the patients occupied. But it should be more dynamic to my mind.'(SN 12)*

The SN said they could only 'keep an eye on the patients and no more' while the NA observed that when the qualified nurse was in the office dealing with administration, he could not alone provide rehabilitation activities for 19 patients. Both felt that four staff per shift were needed for such a programme to be viable. The CN and the NO maintained that improved staffing would enable a more diverse and dynamic programme of activities to be offered thus reducing boredom and concomitant frustration. The other NA, however, expressed the view that qualified staff did have time to play games with patients but chose not to do so. In his view, incidents occurred because patients were bored and he had suggested steps to remedy this, such as a greater range of games and encouraging independence, such as serving their own meals. However, these suggestions had not been followed up because:

> *'I'm only a nursing auxiliary.' (NA 2)*

ii) Medication

The NO expressed anger with medical staff for reducing medication for these patients without discussion with nurses. In his view reduction in medication meant that patients were more able to participate in activities and this, in turn, required more staff. Observing that the resulting boredom when activities were unavailable led to anger, he commented that this was expressed against nurses and not the medical staff who had changed the policy.

7.15.5 Aspects of daily life

All interviewees mentioned one or more aspects of daily life as relevant to incidents. Lack of cigarettes was mentioned most often (4), with the CN expressing the view that 50% of disputes arose over cigarettes. Most patients were smokers, in the SN's view

partly because they were lonely and bored. Patients had a weekly allowance but it was insufficient to buy the amount of cigarettes desired. The typical pattern was for some patients to spend all their allowance in the first two days of the week and then annoy other patients for its remainder by repeatedly asking them for a cigarette or stealing one from their locker. Although cigarettes were offered when possible, patients became angry with staff when they said they were unable to provide more.

Mealtimes were identified as particular flashpoints with patients in close proximity (2) and arguments and fights occurring when one patient felt another was taking more than his fair share (1). Living on a ward meant lack of sexual activity and the SN felt the ensuing sexual frustration was a cause of aggression. He reported raising this subject with medical staff but they had been unwilling to discuss it.

Requests from nursing staff to carry out particular actions, such as having a bath (2) or not to behave in certain ways, such as smoking in bed (1), were cited as leading to an aggressive response by some patients. The CN highlighted the dilemma for nursing staff with a particular example. A patient became very angry when asked to get out of a wet bed and have a bath while staff replaced the bedding, yet staff had a 'duty of care' to the patient to provide him with new bedding.

7.15.6 Knowing and observing patients

Knowing patients well was mentioned (4). The main focus of these comments was that knowledge of each patient meant having awareness of the best way to approach him when he became agitated or involved in a dispute.

> *'Knowing the patients - to me that's the great thing, because they know you, they know how far they can push you, you know how far you can push them before they go over the top.' (SEN 13)*

Constraints on knowing and observing patients focused on staffing (2). The SN said it was important that managers ensured that the ward was always covered by staff who knew the patients and were unlikely to act in a way that might upset them. The CN said that more staff would facilitate earlier anticipation of incidents. He said that he might be on the phone in the office at the same time as the NA was in the bathroom with an

incontinent patient and, consequently. no-one was with patients in the day-room to anticipate and defuse potential incidents.

7.15.7 Incidents that were not preventable

Preventing incidents with this group of patients was difficult (2). Mood changes were sometimes too sudden to allow time for any preventative strategy to be deployed (1) and some patients were aggressive however they were treated (1).

7.16 LONG-STAY: MANAGING VIOLENCE

All spoke about managing incidents.

7.16.1 Primary management

All interviewees (5) gave examples of primary management strategies that included interpersonal skills and specific interventions. These included trying to calm patients down by talking to them (1), keeping calm and not shouting oneself (1), hovering in the vicinity until patients calmed down (1), taking a firm line by turning off the television or refusing to make tea until patients calmed down (1), sending patients who were arguing off to separate activities (1) and physically grabbing a patient about to smash a window (1).

7.16.2 Secondary management

If situations could not be contained, requests were made to the nursing office for additional staff (3) since two was an insufficient number to deal with incidents (3). This was followed either by restraint and medication or by transferring patients to the locked ward. An NA expressed the view that extra staff were summoned too readily and he felt uneasy about subsequent events such as restraint.

7.17 LONG-STAY: POST-INCIDENT EVENTS

A question on events following incidents evoked two types of response: that if physical violence occurred details were recorded in the incident book (2) and that no discussion took place after incidents (2). The NO corroborated the latter point and said that staff did not talk about incidents but should. since this would help improve future practice.

He described himself as one of the worst offenders in this respect both as a CN and now an NO and attributed reluctance to discuss incidents as follows:

> *'Something to do with the macho thing - when you get hit - its sissy to talk about it. Men are more likely to laugh and say "you should have ducked"...deep down it's about feeling sissy.' (NO 7)*

7.18 LEARNER NURSE PLACEMENTS

The ward was not included in the teaching circuit although the NO thought it would provide ideal experience. He also thought that learner nurses should have a placement in the locked ward since it provided the opportunity to watch others managing incidents. In his view, tutorial staff were unable to prepare learners in relation to violence because they had had so little experience of it themselves.

7.19 LONG-STAY: FEELINGS ABOUT VIOLENCE

When asked about their feelings in relation to incidents, all five interviewees discussed being scared. The three qualified staff said that they did not feel scared. The CN added that, nonetheless, the job was very stressful. This was manifest in feeling very tense and irritable when he got home and needing time to himself before responding to family demands. The SN said that he had become familiar with patients and situations over the years and the SEN that he felt safer on the ward than when out on the street. Both NAs said that, although they were now familiar with the patients, they did feel scared on occasion. One expressed the view that his life could be in danger if a restraint had to be undertaken with only two staff on duty.

Despite his years of experience, the NO still felt scared when faced with incidents. Nonetheless being hit by a patient who was, for example, hearing voices was an acceptable risk and that people who found this unacceptable should not come into psychiatric nursing. Being hit by patients who did know what they were doing was unacceptable, however, and he thought that such patients should be discharged.

7.20 LONG-STAY: RIGHTS AND LEGAL POSITION

The SN and SEN discussed their views on the legal position of nurses in relation to violence and neither regarded it as problematic. The SN's response was that. in the event of an incident, he and the NA wrote a report and no-one else would have been present to suggest that anything other than what they had written had occurred. The SEN spoke about always having a clear conscience about his actions, although he did comment that nurses had sometimes been blamed when patients were hurt during restraint. The NO, although now a manager himself, held the view that management did not support staff involved in such incidents even when staff had been acting in good faith.

7.21 CONTINUING CARE: OVERVIEW

This chapter has provided a detailed account of the views and experiences in relation to violence of nursing staff working in a medium-stay and a long-stay continuing care setting. Violent incidents occurred in both settings. All staff had been involved in, or witnessed, incidents and some had been assaulted. Some but not all admitted feeling scared on occasions. This final section draws together key findings including interviewees' perceptions of factors that had a positive impact on the ways in which they were able to relate to violence and those that had a negative impact.

Positive factors included their own skills and experience. On the medium-stay ward, positive factors also included formulating plans through discussion, learning from post-incident discussion and having a long-standing team.

Factors that were perceived as impacting negatively in both settings included recently admitted groups of long-term patients, insufficient staff and inadequate provision of activities and therapeutic programmes. There was concern about learner nurses no longer gaining experience in acute care settings.

On the medium-stay ward, some felt that there was a lack of clarity about their legal position over aspects of the care of informally detained patients. Patients' rights were perceived as being more highly valued than those of nurses. A distinction was drawn

between feeling angry with patients perceived as knowingly assaulting staff, and not feeling angry with patients perceived as assaulting staff because of their illness.

Views differed in both settings over the frequency of incidents, whether medical staff took notice of nurses' opinions, the extent of nurse managers' involvement in ward life and support for staff involved in incidents. On the medium-stay ward views also differed over which incidents merited recording, the degree of pre-planning prior to managing incidents and whether female staff supported male staff in managing incidents.

CHAPTER 8 : VIOLENCE IN REHABILITATION SETTINGS

This chapter focuses on the two rehabilitation settings included in the study: a residential hostel (Sections 8.1 to 8.11) and a day hospital (Sections 8.12 to 8.22).

8.1 HOSTEL: PROFILE OF INTERVIEWEES

The five interviewees from the residential hostel (referred to as hostel hereafter) included a male charge nurse (CN) and a female enrolled nurse (SEN) from the day-duty A shift, a female staff nurse (SN) and male nursing auxiliary (NA) from the day-duty B shift and a male enrolled nurse (SEN) from the night-duty shift. They amounted to half the staff on each shift. Interviewees' ages ranged from early 20s to late 40s and they included three different ethnic groups. Year of qualification varied from two to 20 years ago and the NA had 22 years' experience. The three men had experience in all services whereas the two women had worked only in rehabilitation and elderly care services. Time at the hostel ranged from two to nine years. The nursing officer (NO), a white man in his early 50s, had been qualified for over 25 years.

8.2 HOSTEL: THE SETTING

All interviewees provided information about the setting.

8.2.1 Patients and programme

The programme at the hostel was designed to equip patients with skills for living in the community, either independently or in a group home. A multidisciplinary rehabilitation team, which included hostel nursing staff, assessed patients on continuing care wards as to whether they were sufficiently well to benefit from the programme. The population averaged 30 and 28 were in residence when fieldwork started.

Patients were described as diverse in terms of psychiatric diagnosis and degree of institutionalisation. If patients relapsed, they returned to their ward temporarily. The CN said that, unlike in some rehabilitation units, hostel policy was not to veto admission of substance misuse patients nor those diagnosed as having a personality disorder.

There was, however, a policy of no more than five of the latter since, according to the CN, a larger number would form a subgroup of residents and cause problems.

The ground floor contained a dining room, recreation area, nursing and medical offices and individual treatment rooms. Floors above contained individual residents' rooms and communal kitchen and bathroom facilities. During the day, patients either went to one of the therapy departments or remained at the hostel for skill development sessions. Although hospital policy was for patients to move to the community as soon as ready to do so, some had to wait several months for available, suitable accommodation.

8.2.2 Nurse staffing levels

The day-duty shift usually comprised a CN or SN, and two SENs and one NA or vice versa. While each shift usually included at least one man, on occasion all staff on duty were women. The NO maintained that a higher staffing ratio was required to achieve the aims of the programme. In the CN's view, the number of staff was adequate but the skill mix was inappropriate for three reasons. Recently appointed staff did not have adequate rehabilitation experience. Apart from himself and the other CN, the qualified day staff were all women, most fairly recently qualified. Consequently, he was often the only person on duty with the experience and willingness to cope with incidents. He thought that all staff should be qualified but on some days half the shift complement was NAs. The NA, however, thought that staff of his grade had most to offer the patients:

> *'We are in the front line and nearer to the patients [than the qualified staff are] and the nearer you are the more you can help.' (NA 3)*

At night, two enrolled nurses were usually on duty. The policy was for at least one to be a man in case patients became aggressive. The SEN regarded two staff as sufficient given that most patients did not need much assistance, as did the night-duty SNO on the grounds that nearby staff could be summoned if needed.

8.2.3 Medical staff and nursing managers

Medical staff visited the hostel to assess patients' progress and, when requested by nursing staff, to review those reported as relapsing. The NO likewise visited when requested.

8.2.4 Suitability for admission

While commenting that only rarely was a decision made not to accept a patient. the CN said it was, nonetheless, important that hostel staff retained control over the referral process. The current climate of ward closures and hastening moves to the community had led to pressure from nursing management to accept patients whom the team felt were unsuitable for the programme:

> *'and they've tried to use us as a dumping ground under the rehab wagon.' (CN 5)*

8.3 HOSTEL: DEFINITIONS AND INCIDENCE

The qualified staff (4) regarded violence as involving a physical assault on another person. These four interviewees and the NO said that violence was rare; examples included fist fights between residents and residents slapping each other or a nurse. Aggression was more common and manifest by throwing objects, such as crockery and chairs, smashing windows or the television, kicking doors and verbal abuse. The SEN observed that verbal aggression was more frequent at night since there was less opportunity than during the day to release frustration in outside activities. In the CN's opinion, the overall level of disturbance had increased as ward closures and greater pressure on remaining beds had made it more difficult to transfer relapsing patients to their wards.

Qualified day-duty staff (3) and the night-duty SNO reported that incidents were much more likely to be caused by non-residents. These people included residents' relatives, ex-residents who wanted to live in the hostel again and patients attending the industrial therapy unit who came to the hostel for lunch. The policy that the latter group could use the canteen was much disliked by hostel staff, particularly as numbers were increasing (CN).

8.4 HOSTEL: SOURCES OF GUIDANCE

All interviewees spoke about one or more sources of guidance upon which they could draw.

8.4.1 Education and experience

Qualified staff (4) spoke about their own training about violence with all referring to experience gained during placements, particularly those in acute services. These acute service placements had been a source of anxiety for both female staff in that the SEN said she had opted against a locked ward placement as she feared the level of violence and the SN, although enjoying her locked ward placement, had found it frightening and had not wanted to work there subsequently. Describing being kicked by a patient she said:

> *'I just stood there, I was shocked, I didn't know what to do, should you run or whatever?' (SN 13)*

The male SEN felt that ward staff had provided students with little guidance on the subject and that school teaching had focused on action when attacks appeared imminent:

> *'We would have talks in school of trying to distract the patient, if the patient has a knife or something how to get them to talk about something.' (SEN 15)*

In the CN's experience, more recently qualified staff, including those at the hostel, were not as well prepared about violence as students had been previously. When this was discussed with these staff, the female SEN felt that she had been well prepared whereas the SN felt that she had not but that nurses could only become prepared through subsequent experience. The NA said that courses about violence were important for auxiliary staff when first appointed but I failed to ask whether he had attended one.

The CN and the male SEN said that post-basic training on violence was not provided at the hospital and attributed this to lack of willingness to recognise that it was a problem. The SN, however, reported that a study day had been held although she had not been able to attend. Such courses were needed (3), particularly on the management of violent episodes (2) and on reasons for violence (1):

'There should be more workshops, discussion and role play and awareness exercises as far as violence is concerned. It's not, it's completely swept under the carpet.' (CN 5)

In discussing how they had learnt about violence, the three male staff and the NO referred to acute service experience in this hospital and elsewhere. The CN maintained that reduction in violence over the years meant staff gained less experience than hitherto. The two female staff said that they had not encountered physical violence in the services in which they had worked. The SN and night-duty SEN also referred to learning from observing more experienced staff.

8.4.2 Guidelines

Qualified staff (3) said that hospital guidelines on violence existed but all regarded their value as limited. Observing that the guidelines focused only on restraint, the CN said detailed guidance was needed on preventing and managing violence of the kind available for dealing with fire:

'Fire is a dangerous situation where people can get hurt. Now there's a clear, structured step-by-step as what to do. It's drummed into people. Handling violence has the potential to cause harm to yourself and to other people. We've got nothing. Really you need an ABC.' (CN 5)

The lack of such guidelines led, in his view, to situations in which:

'... people are very hazy, very vague, everybody scatters about squawking like a chicken, not knowing what to do.' (CN 5)

The SN described the guidelines as being quite old and, although 'handy sometimes', were not relevant to most situations. The problem identified by the night-duty SEN was that individual staff, among whom he included himself, tended to read policy documents such as those on violence and then put them aside rather than getting together to discuss their relevance to nursing care. Moreover, there was no system for filing documents in a manner for easy access.

8.4.3 Discussions with colleagues

At handover, the CN drew attention to patients whom he felt should be observed closely. The night-duty SEN said that night staff drew the day staff's attention to patients whom

they felt needed reviewing by medical staff; however, he said that day staff did not like their involvement and had not followed up their recommendations.

The CN and night-duty SEN noted a lack of willingness among staff to discuss strategies for preventing and managing incidents. Both men felt that such discussions would lessen staff fear of violence and increase their confidence in coping with it. The night-duty SEN observed that this was a strategy that lay within nurses' power to implement and thought staff should be more willing to discuss violence together and to role-play ways of defusing incidents.

> *'I think it is important that staff should sit and discuss this patient, knowing what he can become. They never really look at it in depth and say "Well look, we should start doing something about this now, because he might do something."' (SEN 15)*

Possible reasons for such reluctance were pursued with both interviewees. The CN observed that nurses who lacked experience of violence did not recognise the need for discussion. On reflection, the question I should have asked him was why did he not give a lead in starting such discussions but I missed the opportunity. The night-duty SEN attributed reluctance to a general inertia among staff to improve any aspect of nursing care. Although he said that nurse managers did not give a lead in encouraging staff to discuss violence, he commented that there was nothing to stop staff doing so and included himself in the inertia which meant that they never did:

> *'We don't do it ourselves you know. And yet it's there for all of us if we wanted to talk about it or try to act out or role-play a situation, it's there for us to do but none of us wants to do it.' (SEN 15)*

The night-duty SEN attributed nurse managers' reluctance to discuss violence to the existence of a group of staff regarded as having the confidence and competence to deal with incidents that had escalated beyond the control of staff on the ward in question. The status within the hospital of this group, some of whom had long-standing friendships with nurse managers, depended on this ability and, in his view, it was in their interest that other staff did not gain similar confidence and competence. The night-duty SNO also made the latter point.

8.5 HOSTEL: EXPLAINING AND PREVENTING VIOLENCE

All interviewees (5) discussed the explanation and prevention of incidents.

8.5.1 Patient attributes

i) Mental illness

All qualified staff (4), the NO and the night-duty SNO spoke about mental illness. While patients were described as being well on admission, relapses into psychosis, paranoia and depression occurred, sometimes accompanied by aggressive behaviour. The night-duty SEN also referred to patients with schizophrenia developing patterns of aggressive behaviour during years of hospitalisation which they found hard to break.

Day staff regarded mental illness as a more important factor among non-residents than residents. Ex-residents who had been transferred to their ward when relapsing sometimes returned to the hostel and behaved aggressively towards staff and current residents (3). Some of those using the canteen at lunch-time were said to be 'very disturbed', as were some relatives (CN).

ii) Substance misuse

The SN and the night-duty SNO said that the main causes of incidents were drug and alcohol use. While the night-duty SEN allowed patients to have a drink in the evening in preparation for community life, he recognised that this had to be controlled and that other staff might disapprove.

8.5.2 Structural environment

Staff had requested a separate canteen for non-residents in order to avoid both the irritation caused by overcrowding and the increased likelihood of non-residents intruding into other parts of the hostel. The decision had to be made by nursing management but they had not, as yet, acceded to staff requests.

8.5.3 Interpersonal environment

Four interviewees spoke about interactions between nurses and patients. Interpersonal skills deployed to prevent incidents included being understanding (1), having a diplomatic approach to requests (1), and encouraging patients both to discuss frustrations and concerns rather than bottling them up (1) and to say they were feeling

unwell without fearing the consequences (1). Although relating to non-residents was often difficult since many were unknown to staff (2), strategies included responding to people's requests as far as possible (1) and being tactful when asking them to leave the premises (1). The night-duty SEN commented that night staff were able to spend more time than day staff talking with patients since their time was not taken up with administration. The NA found that patients were more willing to talk to NAs than to qualified staff since they were likely to be of the same social class.

The CN and night-duty SEN said that nurses could become angry when patients were verbally aggressive towards them. When feeling 'got at' they responded by saying that patients would be punished in some way if they did not desist, but this only evoked further aggression. Similarly, repeated patient behaviour that nurses found irritating could provoke them to react angrily, only to find that patients responded in kind.

Views differed over whether gender of nurses was relevant. The CN felt that if a male nurse approached an angry male patient, the patient became angrier, but would be more likely to calm down if approached by a female nurse. The female SN, however, felt patients' responses depended upon relationships with, not gender of, nurses.

8.5.4 Programme of care

Several aspects of the rehabilitation programme were identified as evoking emotions that led to incidents.

i) Medication

The CN spoke about medication. Some patients became agitated as their medication was decreased as part of the rehabilitation programme; others became angry when they felt that they no longer needed any medication but staff counselled them otherwise. While supporting the policy of reducing medication, the CN felt that it was applied uncritically. In his view some patients needed more medication than currently prescribed since this would reduce the aggression that hindered their benefiting from the rehabilitation programme, whereas others needed a complete break from medication in order to assess its effectiveness in reducing aggression. He felt that several other professional groups were making decisions about medication levels but that nursing staff, as those closest to patients, were best placed to judge what was appropriate in

individual circumstances. The two SENs said that nursing skills included helping patients cope with relapses without becoming aggressive and cope with the effects of reduced medication.

ii) Rehabilitation programme

Both SENs referred to patients' anxieties about the programme and the importance of nurses' guidance when patients felt they were not making sufficient progress, for example being able to cook their own breakfast. Some patients became anxious at the prospect of moving to the community (day-duty SEN). Residents who broke the drug misuse policy became angry when told they would be discharged (night-duty SEN). Patients who had returned to their wards because no longer able to benefit from the programme sometimes returned to the hostel and became angry when asked to leave (CN).

8.5.5 Aspects of daily life

Patients could cook breakfast using their own resources in their own rooms at any time in the morning. Alternatively they could cook using communal resources in the dining room but only up until 9am. Patients who came down later would get angry with staff when told they would have to use their own resources and cook upstairs (2). Both SENs said that residents argued, for example over cigarettes, and could get on each others' nerves. The night-duty SEN observed that irritation with events could build up during the day and then patients expressed their anger during the evening.

Incidents were more likely, however, to involve non-residents with lunch-time being a flash point (CN). The policy of non-residents using the canteen led to an extremely crowded situation with people sitting very close to each other and tempers became frayed. Moreover, some non-residents criticised the quality and quantity of food and were verbally aggressive to nursing staff who were serving. Having been allowed into the canteen for lunch, non-residents would sometimes go upstairs and enter patients' rooms who, in turn, became upset and/or angry.

8.5.6 Knowledge and observation

Reference was made to observing for signs that patients were relapsing (1) or that an incident might be imminent (1). Although relating to non-residents was often difficult

since many were unknown to staff (2). observation was still important (1). The CN stated that more recently qualified staff had seen so little violence that they did not recognise it was developing and so did not act to prevent it.

8.6 HOSTEL: MANAGING VIOLENCE

All interviewees (5) described managing incidents.

8.6.1 Primary management

Responses defined as primary management included interpersonal skills and letting aggression run its course.

i) Interpersonal skills

Interpersonal skills included calming patients down through talking to them (2) and encouraging taking of prescribed medication in those instances when it was felt this would control aggression (2). Pursuing the latter point, the CN spoke about the dynamics of persuading informal patients to take medication. When a patient refused on grounds of being informal he reminded them that they had agreed to receive treatment:

> *'So there is a veiled threat behind that, which means that if you don't agree with the treatment, the consultant will discharge you.' (CN 5)*

The night-duty SEN said that patients who threatened to attack him usually backed down when informed that if they went ahead he would call the police and that sometimes shouting at patients who were fighting was sufficient to achieve cessation. Intruders who became aggressive when asked to leave were escorted off the premises (2).

The CN, who had observed that some staff did not recognise signs that an incident might be developing (Section 8.5.6), said that even when recognition did occur they lacked the confidence to handle it. This was particularly the case with recently qualified female staff who, in his view, were afraid of patients who became aggressive and consequently made no attempt to calm down situations which might otherwise escalate:

'They turn their backs on it and hope that somebody else handles it.' (CN 5)

The CN also felt, however, that notwithstanding staff lack of confidence, he was expected to handle incidents partly because he was in charge but primarily because he was a man:

'I could have five staff out there now. I can guarantee that if an intruder walks in through that door, and it's a male intruder, or a violent female intruder, they'll be knocking on this door and asking me to handle it.' (CN 5)

The consequence of female staff avoiding managing incidents was that he always needed another man on duty to provide help or else had to summon help from elsewhere. Although the CN thought that training of more recently qualified staff was inadequate (Section 8.4.1) he nonetheless felt that he should be more supported, particularly since, in his view, female staff were more likely than male staff to calm down aggressive male patients (Section 8.5.3). The qualification to deal with violence, in his view, was skill and experience not gender and continued:

'We should now be moving into a non-discriminative, non-sexist society, and, if women are striving to uphold that ... if women have the right not to be used, men have the right not to be used.'(CN 5)

The night-duty SEN also said that staff dithered when incidents were developing but in his experience this was due to anxieties about being blamed if patients were hurt.

ii) Letting aggression run its course

Allowing patients to express anger was described as a means of preventing escalation (2). For the SN this entailed accepting a broken window if this released aggression that might otherwise be manifest in a more serious act. Moreover, once aggression was released it became possible to talk to patients and help them calm down. In similar vein, the night-duty SEN said that by the end of the day some patients were very angry about events which had occurred and that he encouraged the verbal expression of this anger even if this meant patients shouting at him since, in his view, this decreased tension and the likelihood of escalation. In relation to a particular female patient he also allowed her to punch him in the chest as a means of relieving aggression:

'I wanted her to punch me ... Because I felt she needed to hit out at somebody ... She wanted to get something out of her system, and if she knows that pounding me in my chest is going to help her, I don't see why not, it's not hurting me.' (SEN 15)

He added that while other nurses might not agree with his approach on grounds that nurses should not allow patients to hit them, he had to use his judgement with patients he knew well.

8.6.2 Secondary management

Interviewees' responses about secondary management included decision-making, staffing and summoning help, and methods used.

i) Decision-making

The CN was unable to give a precise answer about decision-making:

'To be honest I couldn't tell you. We just do it. You just do it. I couldn't provide a specification as exactly how you do it. It takes an understanding of your patient ... and awareness, plus your own experience. You use, you delve deep into your resources and know-how in order to do that.' (CN 5)

He added that that he would deal with incidents whereas others would call for help. For the SN it was a question of staff knowing what to do. She illustrated this with the example of working with another nurse when patients started to break windows or throw furniture about:

'If the nurse working with you starts running away but she's supposed to get the other patients out. They need to know what to do, they need to either go and get help or disperse the other people out of the room in case they get hurt .' (SN 13).

The NA said his response depended on who else was on duty. If the CN was on duty, the NA said he would call him over to deal with the incident and only became involved if asked to do so. When the shift comprised female qualified staff only. he knew that they depended on him to help with incidents and so he took part without being asked.

ii) Staffing and summoning help

The CN and SN called a doctor when they felt that patients were relapsing and that decisions were needed either to increase their medication or to transfer them to their own ward or the locked ward. Doctors were sometimes delayed, however, and meanwhile the situation often escalated. If staff on duty were unable to cope in the interim, they summoned help through ringing the alarm bell (3) although the SN said the response was not always sufficiently fast. The NO said he was only called to the hostel if there was a violent incident and these were very rare.

iii) Methods of management

The CN and SN stated that ward closures meant increasingly that management by transferring patients to their ward could not be used. On occasion this resulted in patients sometimes being transferred to the locked ward when it was not really necessary (CN).

In relation to intruders who had become difficult, the CN said there was little point in calling security staff to remove them since they were usually of very limited help. Nurses having to cope with intruders, however, was tantamount to treating them as 'bouncers'. Constraints on transferring patients and not having effective security personnel meant that staff had to rely on their own skills. The CN described managing patients who should have been transferred as placing unreasonable demands on hostel staff:

> *'So we've got to contain our own disturbance here as well, and this is a heck of a bloody place to contain disturbance, I can tell you that.' (CN 5)*

On occasion staff had to restrain patients who were fighting (3). Views (3) about learning physical restraint techniques differed. The CN and night-duty SEN said that nurses needed but did not receive this training. The SN, however, thought it better to learn from experience since having courses might encourage nurses to restrain when other approaches might be more appropriate. The CN maintained that role-playing would be helpful in learning how to restrain without causing injury but thought that many nurses resisted this since they felt uncomfortable about the physical contact entailed.

8.7 HOSTEL: POST-INCIDENT EVENTS

All five interviewees spoke about post-incident events.

8.7.1 Discussing incidents

For the CN, the importance of post-incident discussions lay in identifying better strategies for future incidents. The SN usually talked with colleagues about what had happened, but felt reluctant to do so when the shift included people who she thought might be critical of her actions. The night-duty SEN also reported that discussions were held but that these took the form of gossip and reliving the drama rather than a critical analysis of events:

> *'It's just a swapping of accounts. It's news of the world. It's something to talk about, you know. It puts some excitement into work.' (SEN 15)*

The NA said he could not remember such a discussion, possibly because he was not invited to attend but, in any event, did not regard them as useful:

> *'It's alright in a way, but it doesn't change the way it happened. Incidents will happen whatever you discuss about them.' (NA 3)*

The two female staff said they asked patients why they had been aggressive and the SN added that this information could help prevent further such incidents.

8.7.2 Post-incident support

Various views were expressed about post-incident support. The SN said that emotional and practical support was forthcoming from colleagues. While no criticism was offered of the individual nurse manager's response when there was an incident, the attitude of nursing management as a whole was criticised by the night-duty SEN who felt that they should be more supportive of staff involved and by the NA who felt that they had been unsupportive when he had been subjected to verbal racial abuse.

8.8 HOSTEL: LEARNER NURSE PLACEMENTS

The hostel was included in the teaching circuit for psychiatric and general nurse learners. Views about teaching were obtained only from the SN. She said that staff

waited until learners had settled into the work before discussing aggression and violence. In the meantime learners were told not to approach patients who staff thought might be physically or verbally aggressive since staff did not want learners involved in incidents early on in their placement. With regard to school teaching about violence. the SN thought learners would have a lecture on the subject but was unaware of its content.

8.9 HOSTEL: FEELINGS ABOUT VIOLENCE

Interviewees (4) discussed their feelings about violence. The CN described having to contain himself and not cause harm to patients, and anxieties that someone might get hurt. The night-duty SEN and NA responded in terms of 'standing their ground'. For the former this meant defending himself if assaulted and justifying that he had acted in self-defence. The NA described responding with verbal threats when subjected to racist verbal abuse. None of the male interviewees reported feeling scared in the face of incidents at the hostel. The CN had observed that inexperienced female staff became scared when incidents developed and, in this respect, the SN said her fear focused on situations getting out of hand but went on:

> *'You just have to kick yourself and tell yourself to get on with it.' (SN 13)*

The CN also spoke about dissipation of feelings after incidents in which it had seemed that physical restraint would be necessary but had been averted:

> *'What I find is when people sort of get primed for fighting they've got to fight somebody.' (CN 5)*

Referring to a particular incident in which restraint had been averted he said:

> *'And in fact after the patient left there was nearly a fight between the security man and the nurses.' (CN 5)*

8.10 HOSTEL: RIGHTS AND LEGAL POSITION

Four interviewees discussed aspects of patients' and nurses' rights and nurses' legal position.

8.10.1 Balancing patients' and nurses' rights

Balancing patients' rights with staff safety was seen as a complex matter of civil liberties (CN and SN). Both referred, again, to situations in which they felt that medication was necessary to reduce aggressive behaviour by patients who might otherwise constitute a danger to others. There was a dilemma when patients refused medication in that its forcible imposition would transgress patients' civil liberties, but otherwise staff would have to manage the ensuing aggression. The CN felt that this issue was 'a nettle which had not been grasped' and that staff had to rely on their powers of persuasion. The SN also felt there was lack of clarity over whether nurses could search and restrain informal patients.

Three interviewees felt that managers gave precedence to patients' rights over those of nurses. The night-duty SEN and the NA spoke about anxieties that in the event of an inquiry following an incident, the patient's viewpoint would take precedence over that of the nurse. Staff feared that if patients were injured during incidents and made a complaint against nurses, then in any ensuing investigations they would automatically be held responsible and their job security possibly jeopardised. The CN spoke about management reluctance to encourage staff to bring charges against patients who had knowingly attacked them. He said that charges were only forthcoming if patients admitted the attack and consequently patients often escaped censure for unreasonable actions.

8.10.2 Effect of concerns about legal position

There was some indication of a growing reluctance to participate in managing incidents. The night-duty SEN said he would get involved but noted a growing reluctance to respond to calls for assistance on other wards. He attributed this to concerns that management support would be lacking for those involved if a patient made a complaint. It was this anxiety about subsequent repercussions that led the NA to say:

'If I saw two patients fighting in the past, I would have gone in. Now I would rather leave them and go and tell the charge nurse - you have to cover yourself.' (NA 3)

8.11 HOSTEL: INCIDENT EXAMPLE

The following incident, described by the CN and NA, illustrates points discussed in the foregoing sections.

8.11.1 The incident

A patient had become increasingly unstable and, following protracted discussions with medical staff, had been transferred to his ward. The patient, described as large, very aggressive and difficult to handle, returned to the hostel. The NA said a female SEN saw the patient enter the kitchen, followed him and told him he should not be there and then called for the NA. The NA said he entered the kitchen and the patient tried to escape from him by climbing through the serving hatch into the dining room. Having obtained a coffee from the machine, the patient went upstairs. The NA said he then called for the CN. The CN, however, said the female SEN came into the office and told him what had happened.

The CN said that he and the SEN went upstairs and found the patient trying to enter his old room. When the CN asked the patient to return to his ward he became very angry. Although the CN persuaded the patient to walk towards the stairs he then threw his coffee in the CN's face. The CN said he had to stay there rather than go to summon help from other hostel staff since otherwise the female SEN would have been left on her own with the patient. The CN said he then persuaded the patient to go down the stairs, keeping his hand firmly on his shoulder. He explained that he thought the patient would not turn round and hit him as he himself would then be vulnerable to being pushed down the stairs. When they reached the ground floor the patient turned round and 'squared up' to the CN and threatened to 'break his face'. At this point the NA grabbed his arms.

The NA gave a slightly different account. He said he ran upstairs in response to a call from the SEN and saw the patient and the CN struggling. He grabbed the patient's hand who told him to let go so he could hit the CN. The NA said that he and the CN then took the patient back to his ward. According to the NA, the CN had written a report that

the NA had been shown, but if there had been a discussion then he had not been included.

8.11.2 Subsequent reflections

The CN described several dilemmas that this incident raised. The hostel was out of bounds to the patient. If the CN allowed him to stay this would be inconsistent with his previous decision that the patient was not well enough to be there. If he insisted the patient left, people might ask why did he not allow him to go upstairs and drink his coffee in peace rather than possibly risk an aggressive response. However, if the CN had done this and the patient had attacked a resident, people would blame him for having known that the patient was there but not having taken action. The CN felt the situation did not merit summoning help from elsewhere and decided to see if he and the staff could manage. He said, however, that had he not been on duty the female staff would have summoned staff from the patient's ward. The CN thought that the patient was angry with him personally because as the nurse in charge he had been responsible for requesting the patient's transfer out of the hostel. He wondered whether the patient would have left if requested to do so by female staff and whether as a man his presence had exacerbated the situation. In retrospect the CN felt the situation had been handled well without the patient hitting anyone.

8.12 DAY HOSPITAL: PROFILE OF INTERVIEWEES

Two of the three staff who worked in the day hospital were interviewed: the charge nurse (CN) and one of the two staff nurses (SN). The CN (early 40s) had qualified 18 years ago. He had experience in all clinical settings and had worked at this hospital for 14 years, the last six at the day hospital. The SN (29) had qualified two years ago and had worked mainly in rehabilitation settings. She had been at this hospital for one year working only at the day hospital. Both interviewees were members of ethnic minority groups.

8.13 DAY HOSPITAL: THE SETTING

Both interviewees provided details of the setting.

8.13.1 Patients and programme

The day hospital provided services both for patients resident on wards and nearing discharge and for those already living in the community but needing continuing support. A multidisciplinary conference was held to decide whether referred patients were sufficiently well to benefit from the programme. While a history of violence did not preclude admission, criteria included minimal likelihood of aggression partly because junior staff did not have skills in restraint.

A programme of activities (art therapy, music workshops, cookery, woodwork and keep fit) was provided for patients on weekdays by nurses, and by Local Education Authority tutors who visited on a sessional basis. Nursing staff also led groups on problem-solving and decision-making. The ground floor contained the nursing office and various activity areas for patients, while the upper floor contained office space for medical staff, clinical psychologists, occupational therapists and secretaries. Although there were places for 60 patients, 38 were registered at the time of fieldwork. Each week an average of one new patient was accepted and one discharged. Length of attendance varied from a few weeks to more than a year.

8.13.2 Nurse staffing levels

Three nursing staff were usually on duty, occasionally two. Both interviewees felt two staff was insufficient. The CN said the staff complement should include three rather than two staff nurses but felt it unlikely that nursing management would sanction recruitment of a third. The SN said short staffing increased her feeling of vulnerability when encountering incidents.

8.13.3 Medical staff and nurse managers

Three observations were made. The day hospital NO was regarded as unsupportive over failure to provide additional staff and over moving staff from the day hospital without prior discussion. Disagreements between managers of nurses and of occupational therapists about division of responsibilities between the two groups of staff had led to occupational therapists being withdrawn from the day hospital. The SN said that this

loss was felt keenly and at least two were needed for the programme to function properly. Relationships with medical staff focused on requests for patients to be transferred back to their own ward.

8.13.4 Patients' routes to admission

Both interviewees said that patients had never been referred who had been too difficult to manage from the outset although in retrospect some patients had been referred too soon. If patients relapsed, however, to the point when their behaviour was disrupting the progress of others, a request was made for them to be transferred back to their ward.

8.14 DAY HOSPITAL: DEFINITIONS AND INCIDENCE OF VIOLENCE

Both defined violence as involving a physical attack on another person and the SN added that throwing furniture was violence. The CN regarded aggression as a reaction to emotions such as fear and felt that it could lead to violence. The SN said that whether or not violence eventuated depended on responses to aggression.

Both interviewees said there were very few incidents involving day hospital patients, the SN adding that most were 'well maintained'. Most incidents involved intruders, either current hospital patients or those previously discharged, who caused problems by disrupting activities. Such incidents were fairly frequent (2), occurring weekly according to the SN.

8.15 DAY HOSPITAL: SOURCES OF GUIDANCE

Both interviewees spoke about one or more sources of guidance on which they could draw.

8.15.1 Education and experience

Both reported that the subject of violence had been included in their own training. The CN focused on a valuable student placement in a locked ward where he felt he had been properly trained in managing incidents and felt safe since staffing levels were high. The SN had not had such a placement but wished she had since it would have been useful. During her acute placements other staff had always managed incidents. While her

course had included lectures on causes. prevention and management of aggression, she felt the subject had not been tackled in sufficient depth. Moreover, school teaching was often not applicable to ward situations and as supervision of student practice had been minimal, she had had to use her own intuition and judgement on how best to relate to patients whom she felt were becoming aggressive. Comparing his own training (some 18 years ago) with that provided nowadays, the CN corroborated the SN's view that current day training on violence was inadequate.

Both reported that there was no post-basic training on aggression and violence at the hospital and maintained that such provision was needed. Recommended formats included: attending appropriate ENB courses (CN); having a period staffing on locked wards (CN); rotating to all areas to refresh skills (CN); and having regular study days on violence similar to those on developments in drug treatments (SN).

Both felt that teaching and experience were equally important. The SN stressed the importance of being taught skills first and then having opportunity to consolidate these through experience. While the CN had been involved in management of numerous incidents during training and subsequently, the SN had only witnessed incidents during training and had little direct involvement after qualification.

8.15.2 Guidelines

These two interviewees said that new district guidelines on violence had recently been produced and a copy was now available in the day hospital. Noting that the guidelines covered aspects of behaviour for which to be observant, how to manage an incident and post-incident reporting procedures, the CN felt they were useful for staff whose training had not covered the subject. The SN commented that the guidelines, along with other policy documents, had been lost during an office move. A recent incident, however, had led to a search for the guidelines and although they had been found she had not referred to them as yet.

8.15.3 Discussions with colleagues

Although both said discussions were held after incidents (Section 8.18). the SN added that staff seemed reluctant to talk about the subject between incidents. Attributing this reluctance to herself as well, she said:

'I think it's something you really don't discuss. I don't know why, maybe it needs to be discussed, but I don't know why you don't really, because we are all in vulnerable positions. Maybe it's just something you think won't happen, but it is something that could occur everyday ... Perhaps we're a load of ostriches.' (SN 14)

8.16 DAY HOSPITAL: EXPLAINING AND PREVENTING VIOLENCE

8.16.1 Patient attributes

i) Mental illness

Although all patients had been assessed as fulfilling the admission criteria, some subsequently suffered a relapse (2). The CN observed that relapses led to feelings of insecurity, fear and persecution all of which could be manifest by incidents.

ii) Substance misuse

Examples were given of incidents that were attributed to the effect of alcohol on the patient.

8.16.2 Structural environment

The main strategy deployed against intruders was locking the main door (2). This policy had been implemented some six months previously at the request of patients annoyed by constant interruptions to their group work. The SN said it had deterred 'regular' intruders and also made staff feel more secure. As there was another door into the building to which a lock had not been fitted, the problem of intruders remained, although to a lesser extent than hitherto (SN).

8.16.3 Interpersonal environment

Both interviewees spoke about nurse-patient relationships. Nurses being bossy and over-directive in their approach might be tolerated for a while but then might be met with an aggressive response (CN). If nurses had preconceived ideas that patients might be difficult, perhaps if diagnosed as having a personality disorder, then this might be manifest in an approach of 'expecting trouble'. Patients sensed this and some responded accordingly (CN). Similarly, when patients sensed nurses were anxious in dealing with situations, for example when short-staffed, some took advantage and acted aggressively

(2). Like anyone else patients could have their 'off days' and be aggressive when approached by staff (SN). Sometimes patients wanted to be left alone for a while and not participate in activities and lack of sensitivity to these feelings could be met with an aggressive response (SN).

Both said that ex-patients who were angry at having been transferred back to their wards sometimes returned to the day hospital and then became aggressive when asked to leave. The SN stressed that a calm approach was needed when asking these patients and intruders to leave the premises since a hostile approach 'might put their back up' and lead to aggression. As staff often lacked knowledge of intruders' psychiatric history they were unsure of the best way to approach them without provoking an incident (SN).

The CN thought that race of staff was a factor that could work both ways in relationships with patients. Some patients felt a loss of pride when presenting with mental illness in front of nurses from their own ethnic group and reacted aggressively when asked to do something. With other patients of his ethnic group, however, he felt that he, more readily than white nurses, established relationships with them that militated against aggression.

Turning to gender, the CN thought that in some instances a male nurse would be more likely than a female nurse to provoke aggression from a male patient. The explanation he offered was that the male patient sensed his own aggression, transferred this to the male nurse on the assumption that, as a man, the nurse would also feel aggressive. The patient then responded to the transferred aggression. A female nurse would not provoke such a response. The CN also felt that male nurses often dealt more sensitively than female nurses with female patients, again lessening the likelihood of an aggressive response. The SN, however, expressed the view that neither race nor gender were factors in aggression.

8.16.4 Programme of care

i) Medication

Very few patients were taking medication. The CN recommended that some patients whose medication had been stopped prior to coming to the day hospital should continue to receive it for a while as, in his view, it minimised the aggression which prevented

them benefiting from the programme. When feeling better, some patients thought they would recover further without medication but responded aggressively if nursing staff suggested otherwise (CN).

Some patients, particularly those referred from the community, received regular medication by injection to control symptoms of their illness. The SN commented that when an injection's efficacy was wearing off, mood changes occurred which were sometimes manifest in swearing and threatening behaviour.

ii) Activities and staffing

When patients appeared too agitated to participate in group work, the approach was to work with them on a one-to-one basis since this usually helped them settle down (SN).

When short-staffed, the CN said he enlisted patients' help:

> *'We always inform the patients ... say "look, we are short of staff and I think we've got to depend on you. You've got to help us." And you defuse the whole situation if there's any anxiety. Give them the power, transfer the responsibility and they get satisfaction from organising the group and managing all right despite you not being there.' (CN 6)*

8.16.5 Knowing and observing patients

Both interviewees said their knowledge of patients enabled early recognition of the likelihood of an incident developing. In this event they observed patients particularly closely so that they could react quickly if aggression was manifested. Although the CN had described observation as a strategy used to recognise and prevent incidents, he nonetheless felt that junior staff often did not respond quickly enough to prevent an incident developing. He attributed this to a lack of teaching about violence during their nurse education.

8.16.6 Lack of explanation

The CN commented that he could offer no explanation for some incidents.

8.17 DAY HOSPITAL: MANAGING VIOLENCE

8.17.1 Primary management

The first approach adopted was using interpersonal skills to calm patients down (2) and to ask intruders to leave (2). The SN said that she was sometimes scared of intruders who were becoming aggressive and would ask the CN to persuade them to leave. Like the CN in the residential hostel, the CN in the day hospital said that inexperience on the part of junior female staff meant that they did not know how to cope with aggressive patients. In his view it was this inexperience, rather than a lack of staff, which was the problem.

> *'You can have 12 people in one place, but if no-one has the training or skill then there will be panic in the camp.' (CN 6)*

8.17.2 Secondary management

The interviewees' responses allocated to secondary management related to decision-making, staffing and summoning help, and methods used.

i) Decision-making

While the SN said she felt vulnerable when only two staff were on duty, the point at which she decided on actions, such as calling for help or requesting that patients be transferred, depended not only on the number of staff on duty but also on how confident she felt:

> *'But I think a lot of it is how you feel as well. If you feel that you're able to cope with it, then you tolerate it more.' (SN 14)*

ii) Staffing and summoning help

Both interviewees said that when unable to calm patients down they called medical staff to review patients' medication or authorise their transfer back to their ward until stabilised again. If staff were not able to persuade intruders to leave they called the security officers to remove them from the premises (2) although the SN said that they often took time to arrive.

If nurses could not contain a disturbance until medical or security staff arrived, they sometimes summoned extra help by phoning the nursing office or nearest ward (2). For

the CN such action was necessary since female staff could not restrain patients, whereas for the SN, if on duty with just one other woman, she felt vulnerable about attempting to handle situations without assistance. Relationships with staff of other wards were spoken of favourably in that they came to assist as quickly as possible when called, even though short staffed themselves.

The SN wanted a more effective alarm system for summoning help. She pointed out that all offices for doctors, clinical psychologists and secretaries (present on a sessional basis) had alarm buttons so that these staff could summon help immediately from other personnel in the building. An indicator board in the nursing office showed in which office the button had been pressed. There were no such alarm buttons, however, in the areas in which nursing staff worked with patients and the phone was the only means of summoning help. In her view, there should be an alarm system that linked the day hospital directly to one of the main hospital blocks so that help could be obtained quickly and without having to use the phone. She said staff had requested nursing management to install such an alarm system but nothing had been forthcoming as yet.

> *'We spoke to him, we still don't have an alarm, so I don't think his support's really that immediate. I don't think he's that concerned about us really.' (SN 14)*

The CN said he was aware that his staff felt the current system was inadequate. After a long pause he returned to the point made earlier, namely that staff would feel less vulnerable if their training had equipped them to cope with violence. He regarded staff training as the key whereas junior staff focused on numbers on duty and alarm systems.

iii) Methods of management

Both said medical staff were supportive in reviewing medication. The SN felt that sometimes staff over reacted and requested that patients be transferred before giving them time to calm down; however, she went on to say that they had to do this otherwise group work was disrupted. Staff of other wards were described as willing to take back patients who relapsed, given the capacity to do so (SN).

The CN had learnt techniques of physical restraint during his training and used them subsequently, albeit rarely, at the day hospital. He expressed concern that most junior

staff did not know how to restrain and felt this was a deficit that should be addressed in basic training. He also felt that women did not have the strength that was sometimes required. The SN, however, felt that her small stature would not preclude her from being able to restrain if she had the skills. She advocated nurses being taught these skills in the first six months after qualification and felt it important to acquire these before the need arose. She had just started to learn restraint skills from another member of staff and although not skilled at present, reported supporting other staff managing incidents.

8.18 DAY HOSPITAL: POST-INCIDENT EVENTS

Both interviewees referred to incidents being discussed with patients involved and to incidents that staff had discussed with each other. In relation to a particular incident the SN said it was during the course of subsequent discussion that staff realised how vulnerable they were and had asked their manager for advice about obtaining help more quickly.

8.19 DAY HOSPITAL: LEARNER NURSE PLACEMENTS

Learners had placements in the day hospital. The SN said that she had participated in the learner nurse programme but that she had not covered the subject of violence. Moreover, she did not know what they had been taught on the subject to date. In keeping with views expressed about their own training, both interviewees felt that a locked ward placement was an important learning experience, although the SN added that this should be in learners' final year since any earlier might frighten them into leaving the course.

8.20 DAY HOSPITAL: FEELINGS ABOUT VIOLENCE

The possibility of violence had an adverse effect on both interviewees. The CN said:

> *'It happens to me sometimes that my anxiety level is high, especially if I'm alone [i.e. if on duty with one other person who was elsewhere at the time] .' (CN 6)*

The SN was worried about intruders when there was insufficient staff and was frightened of certain ex-patients with a history of violence.

8.21 DAY HOSPITAL: RIGHTS AND LEGAL POSITION

The CN referred to the dilemma of informal patients being able to refuse medication when staff felt this would reduce aggression. The SN said she had not really given the subject much thought other than that she was aware of the patients' legal position and felt that nurses were more likely to be knowledgeable of patients' rights than of their own.

8.22 INCIDENT EXAMPLES

The following incidents illustrate points discussed in the foregoing sections.

8.22.1 Incident 1: described by the CN

i) The incident

Six months previously a patient had arrived drunk at the day hospital. When asked to leave he had refused and became verbally abusive, threatening to hit people. He went to attack one of the other patients. The staff nearby, two recently qualified nurses and two occupational therapists, did not know how to deal with the situation and were, in the CN's view, more hysterical than the patient. The CN saw what was happening and was able to take the patient to a separate part of the room and talk to him. Later he contacted medical staff and nurses on the patient's ward to which the patient was subsequently transferred.

ii) Subsequent reflections

The CN said that the nurses and occupational therapists were not to be blamed for not being able to handle the incident since this was due to their inexperience.

8.22.2 Incident 2: described by the SN

i) The incident

Just prior to the interview, a patient with a history of violence, currently based on a ward, had entered through the back door and gone into the kitchen. The patient then came into the office where the SN was working:

> *'and he was just standing there and I felt quite frightened because he was very threatening just by standing there, just the way he was looking and also because of his history.' (SN 14)*

While the patient was in the kitchen the SN called the CN to 'come and sort this chap out'. Although the patient left the building when asked to do so by the CN, the SN had felt anxious while he was on the premises since he was 'known to be quite a nasty person'.

ii) Reflections on the incident

The SN said that her sense of vulnerability was heightened because she was pregnant and, although saying that it was perhaps selfish, she had not wanted to place herself in a position of possibly being hurt.

8.23 REHABILITATION SETINGS: OVERVIEW

This chapter has provided a detailed account of the views and experiences in relation to violence of nursing staff working in settings providing rehabilitation programmes: a residential hostel and a day hospital. In both settings the incidence of violence was rare and was more likely to involve outsiders than patients based in the setting. This final section draws together key findings including interviewees' perceptions of factors that had a positive impact on the ways in which they were able to relate to violence and those that had a negative impact.

Positive factors in both settings included skills in guiding patients through rehabilitation activities. Both the CNs referred to their own skills and experience in preventing and managing violence but expressed concern that junior staff lacked such skills and experience. Positive factors in both settings also included other staff coming to assist in emergencies and medical staff coming when asked to assess patients. In the day

hospital, positive factors also included locks on the doors to deter intruders and being taught restraint skills by another staff member.

Negative factors in both settings included lack of effective security staff to remove intruders, lack of discussion about violence other than when incidents occurred and, for the CNs, always having to take responsibility for violence in the absence of other skilled staff. Other factors perceived negatively by hostel staff included lack of guidelines, inappropriate medication regimes, and not being able to transfer patients when relapsing. Interviewees felt that there was a lack of clarity about their legal position over aspects of the care of informally detained patients. Day hospital staff differed in their views about the need for alarms.

CHAPTER 9: VIOLENCE IN COMMUNITY SETTINGS

The community psychiatric nurses (CPNs) provided a range of services. Those members of the team described as generic provided care for any adult patient referred to the service. Others provided specialist services (care of the elderly, counselling, behavioural therapy, and health and social services liaison) and one was a member of the multidisciplinary team based at the community mental health centre.

9.1 PROFILE OF INTERVIEWEES

The seven interviewees included four of the nine generic CPNs, the CPN who specialised in behavioural therapy and the CPN who was a member of the community mental health centre team. The nurse manager specialised in counselling and, as she carried a caseload, material from her interview is included with that from the other six interviewees. The interviewees, one man and six women, had ages ranging from early 30s to late 40s. They were a less ethnically diverse group than the interviewees in institutional settings. All had institutional experience that included acute services and length of time in a community post ranged from eight months to 10 years.

9.2 THE SETTINGS

The interviewees described the patients, programme of care and staffing in the various settings in which they worked.

9.2.1 The generic community psychiatric nursing service

i) Patients and programme

Each generic CPN covered a geographical area with some based in health centres and others in offices at the hospital site. The service had an open system in which referrals were made by health and social care staff, by voluntary organisations and by patients themselves, their relatives or neighbours. Approximately one third of referrals were made by hospital medical staff for patients nearing discharge. The CPN staff assessed the patient to decide whether the service could offer appropriate treatment. If so, agreement to provide care was reached with the patients' medical officer (GP or psychiatrist). If, upon making a home assessment, CPNs thought the patient should be

detained under a section, they contacted the GP and a social worker to make an assessment, since CPNs were not authorised to sign sections.

CPNs visited patients living in their own homes and in group homes aiming to support them in living in the community. This included counselling, giving injections, observing for signs of relapse, ensuring that appointments with various agencies were kept and liaising with patients' social workers and general practitioners. As well as visiting patients by prior arrangement, CPNs were also on a rota for emergency (or crisis) work involving assessment and/or treatment. When informally detained patients absconded from hospital, CPNs visited their home to encourage them to return voluntarily. If patients detained under a section absconded, however, the police were asked to take them back.

ii) Nurse staffing levels

Information provided about workload indicated that these CPNs had a caseload of about 25 patients and usually made five visits a day. Discussions about the feasibility of visiting patients in pairs (Section 9.5.4 ii)) occasioned two CPNs to comment that there was insufficient staff to cover the work:

> *'We can hardly cope with our caseload now. People are overworked and stressed and we can't get relief nurses, never mind be able to go out in pairs for crisis work and assessments.' (CPN 3)*

The DNS said that staffing was being increased.

iii) Suitability for referral

While the nurse manager described working relationships with most psychiatrists as one of mutual respect, she disagreed with decisions made by some not to refer certain patients to CPNs on the grounds that they were too dangerous. Appreciating their concern for the safety of nursing staff, she nonetheless felt CPNs could have coped with these patients, especially since she believed that their aggression was caused by the inappropriate manner in which psychiatrists were relating to them. In the view of another CPN, some psychiatrists misused the CPN service by insisting on referring patients who CPNs had already said were unsuitable for the care that they could offer.

Like psychiatrists, GPs sometimes inappropriately referred patients to CPNs who, in some cases, had already informed the GP that they had discharged the patient (2). One interviewee referred to a case in which she had discharged an aggressive patient, on the nurse manager's advice:

> *'And I did [discharge] but then got a load of abuse from the GP who won't go out because he's afraid of her.' (CPN 7)*

9.2.2 The community mental health centre

The recently opened community mental health centre was staffed by a multidisciplinary team of social workers, occupational therapists, community psychiatric nurses, psychiatrists and clinical psychologists. Services included programmes of treatment for people referred with emotional and psychological problems and a self-referral service for people in crisis. Each day, one staff member was available for new referrals and those who 'dropped in' and a second was available to respond to crises in the home. In the latter event the staff member was usually accompanied by a psychiatrist, in case a section was indicated but also for reasons of safety. Four hundred patients were registered at the time of fieldwork.

9.2.3 Counselling and behavioural therapy

Counselling services for patients referred by their GP or other CPNs were held in patients' homes or at the CPNs' office. The behavioural therapy service focused on agoraphobia, social phobias, obsessional problems and grief resolution. Referrals were made mainly by clinical psychologists for patients in hospital nearing discharge and the CPN visited them to develop a relationship before treatment started. Treatment programmes varied from a few weeks to nearly two years and sessions were held in offices at various sites and patients' homes. At the time of fieldwork there was a waiting list for the service and a second staff member was needed.

9.3 DEFINITIONS AND INCIDENCE

All (7) defined violence as a physical act causing damage to people, with some also including damage to property (1), throwing objects (1) and verbal abuse (1). Aggression was described (6) as being expressed verbally through shouting and/or making hostile or threatening remarks and gestures.

All interviewees (7) said that there was very little aggression and violence from patients in the community. In terms of personal experience, one had encountered physical violence, five had been in situations that they had found very intimidating and one reported neither such event. Although incidents were rare, interviewees could recall each with great clarity, even those occurring some years previously:

> *'I have encountered several intimidating situations in my life as a community nurse. I remember clearly, quite a few distinct ones.' (CPN 4)*

Comments were made (2) about experiencing fewer incidents in the community than when working in hospital. One attributed this to the voluntary nature of the contact between patients and CPNs in that if patients did not want to see the CPN they could refuse to do so, whereas they were not always free to leave hospital. That the contact could be terminated by patients meant that there was less likelihood of anger. The other thought that approaches deployed by community staff were less likely to induce anger than the approach deployed by hospital staff, a view also expressed by the DNS.

Incidents occurred in four situations: visiting patients' homes; transporting a patient from home to hospital; in settings which patients visited (offices in health centres, surgeries and the community mental health centre); and making the journey to patients' homes.

i) Visiting patients' homes

The CPN who had encountered incidents of physical violence in patients' homes reported three such occasions when he had been kicked, punched or slapped. Situations described by other CPNs as intimidating, although not involving physical violence, included verbal aggression and threatening gestures such as 'swinging punches' and 'making stabbing motions'. Verbal aggression was described in terms of tone (shouting, screaming, being very agitated) and content (making threatening statements about what they would do to the CPN or to others, demanding some kind of action from the CPN, refusing suggestions of treatment and expressing anger about their own situation). While most such incidents involved the patient, occasions were reported of incidents

involving relatives. This took the form of shouting at CPNs, racist verbal abuse or pushing them out of the house.

One CPN recounted two incidents in patients' homes that he attributed to undertaking work that was the responsibility of others. One was a request to visit a patient who was angry at being refused money from social services. The other was a request to collect meter money during a routine visit because the patient had refused to give it to the meter readers. In both instances the patient became angry with the CPN. Reflecting on the latter incident the CPN said:

> *'I thought what on earth am I doing? If they can't collect their money and leave with it why involve me? It's not part of my role.' (CPN 6)*

ii) Travelling in the CPN's car

Two CPNs described incidents in which during a home visit they had decided that the patient should be seen by a doctor in the out-patient department at the hospital and had made a judgement that it would be safe to drive the patient to hospital themselves. In both cases the patient had become verbally aggressive and threatening during the journey.

iii) Settings which patients visit

Three CPNs described incidents in premises that patients visited. Three incidents occurred when the CPN was in an office. These included: a couple's therapy session in which the man started battering his partner; a patient getting very angry and banging his fist on the desk; and a patient who was shouting, screaming and throwing furniture about. Other incidents took place in reception areas and included patients getting very angry with staff and, in one instance, a patient threatening to hit the CPN.

iv) Journeys to patients' homes

Attack by members of the public when travelling to patients' homes was of much more concern than incidents involving patients (7). The nurse manager said that the large housing estates in the area had become increasingly dangerous places for staff to visit. All interviewees described possible situations which made them anxious: being mugged (4) for drugs (2) equipment (1) and cash (1); walking past groups of people who looked 'menacing' (1) or harassed you (1); being raped (1); people jumping out from narrow

alleyways (1); people getting into lifts with them (1); having their car broken into (1); and being attacked by dogs (1). Reports were given of colleagues being mugged and although none of the interviewees had experienced this, two had encountered 'harassment' and had been attacked by dogs.

9.4 SOURCES OF GUIDANCE

9.4.1 Education and experience

Interviewees spoke (6) about their training in relation to violence. Five described acute placements in which experiences included: being hit (1); witnessing a lot of violence (1); and feeling frightened when first exposed to it (1). Two highlighted the importance of staff support during these placements. For one this had been manifest by confident staff making her feel secure. The other focused on confidence gained by the end of the course as a result of teaching:

> *'And we were taught how to restrain and how to avoid violence and how to defuse. And that stayed with me over the years.' (CPN 7)*

All references made to school teaching (3) were critical. Teaching staff were out of touch with how difficult situations could be and hence lecture content was unrealistic (2). More emphasis was needed on preventing violence (2), less on not retaliating and more on how to cope (1). Closer collaboration on the subject was needed between service and education staff (1). The subject was not covered in enough depth because staff found it difficult to talk about (1) and there was a lack of clarity about defending oneself if assaulted (1). As one put it:

> *'It seemed to be such a difficult subject for people that I feel there wasn't enough of it during our training. It was sort of slapdash, it was "you don't do this, you don't do that", but never what you can do or ways of coping.' (CPN 3).*

The nurse manager felt that current day training was much better than that which she had experienced in the 1960s. The 1982 syllabus had moved away from a medical model of care towards one which focused on human relationships and, in her view, this was a key factor in preventing aggression.

Post-basic opportunities identified (6) for learning about violence included courses and clinical supervision. Four referred to counselling courses that had been completed (2) or were in progress (2); funding and study leave had been provided by this hospital. Skills gained during the course included techniques to reduce tension (2). Another interviewee described a lecture on the use of body language to de-escalate situations, adding that she had used its content to good effect when a very disturbed patient had locked all the doors after she had entered his house.

The nurse manager provided a monthly clinical supervision session for each CPN (4). Describing their purpose as providing staff with opportunities to talk about their work and/or personal problems if they wished and developing skills for managing difficult situations, she felt that staff needed more clinical supervision than she could provide on her own. The need for more clinical supervision was endorsed by one CPN who paid for additional supervision to help her cope with the difficulties of her patient group.

Despite the foregoing opportunities, most interviewees (5) commented that more post-basic training on violence was needed. Suggestions included developing skills in interpersonal relationships, looking at one's own anger as a means of helping others deal with their anger, sharing experiences on how to avoid violence, encouraging people to examine their own attitudes to violence and developing counselling skills. One CPN offered the view that lack of training on violence indicated that it was a subject that people did not wish to confront.

While the quality of first level education in relation to violence had varied, all had had subsequent opportunities to learn from experiences of witnessing and being involved in violent incidents while working in institutional settings. Two CPNs referred to specific learning points gained from working in community settings: the importance of obtaining information about patients' mental state before visiting, and assessing that patients' mental state was such that undertaking counselling sessions with them would not pose a risk to the CPNs' own safety.

9.4.2 Guidelines

No guidelines were reported as being available which dealt specifically with preventing and managing violence in community settings. Interviewees (2) reported that

development of such guidelines had been under discussion but none had yet materialised. Reference was made (2) to guidelines seen when practising in hospital settings but which were felt not to be relevant to community settings. Although some (2) felt guidelines were needed. others (2) commented that they would be difficult to devise since each situation in the community had to be assessed individually (1) and team members had different ways of handling situations (1). Suggestions for the content of guidelines for community staff included always visiting certain estates in pairs (1) and leaving patients' homes if they became threatening (1).

9.4.3 Discussions with colleagues

A weekly staff meeting for all CPNs included a session for sharing experiences with colleagues (7) and all said the subject of violence was often raised. Topics included how to manage patients whose potential for aggression was causing concern (1), warning colleagues about patients who had shown aggressive behaviour (1) and role-playing:

> *'We'd role-play different situations ... and people would comment and you'd get loads of ideas usually.' (CPN 6)*

Reflecting on the adequacy of such discussions one interviewee advocated a specific forum within which staff could reflect on their attitudes and skills in relation to violence. Another thought that staff avoided discussing violence:

> *'Maybe they just go and try and deal with it when it happens which is the wrong way of going about it because if there are ways in which it could be prevented then people should learn about them.' (CPN 5)*

A monthly meeting of the multidisciplinary team at the community mental health centre focused on staff safety, guidelines and views about handling of incidents.

9.5 EXPLAINING AND PREVENTING VIOLENCE

All interviewees discussed the explanation and prevention of incidents in community settings.

9.5.1 Information about patients

Interviewees (3) spoke of obtaining sufficient information about patients whom they were visiting for the first time in order to make a judgement about whether it was safe to do so alone. Reflecting on a situation in which a very disturbed man had locked her into his flat, the nurse manager said:

> *'I asked for it in the sense that I did not prepare the situation by finding out what was the mental state of this patient, this complete stranger to whose house I went.' (C'PN 1)*

Problems over information were identified in that individuals or organisations making referrals did not always provide sufficient information for CPNs who had to spend time tracking down additional information themselves (2). It was recognised, however, that such information was often not available for patients referred to the service as an emergency and this was one of the reasons for these visits being made in pairs (2).

CPNs tried to support each other by making sure information about patients they were referring to another CPN was adequate (1). GPs placed CPNs in potential danger by not providing information on referral forms as to whether new patients had a history of violence or whether there was any reason to believe that the CPN might encounter such behaviour (3). One CPN expressed the view that 'potential for violence' should be separately itemised on the form but added that GPs might be reluctant to provide this information since it might dissuade CPNs from visiting a patient whom they themselves did not wish to see.

9.5.2 Patient attributes

Some incidents encountered in community settings were attributed (3) to patients' mental state and references were made to psychosis and schizophrenia. One CPN described emergency referral patients as being 'unmedicated and disturbed'. Two incidents were attributed to substance misuse: a drunken relative who made abusive racist remarks to the CPN and insisted that she left the house, and a counselling session

with a patient whose behaviour (screaming and throwing furniture about) was attributed to the effect of drugs. Personal circumstances reported (3) as being the cause of anger and aggression included housing problems, benefits not being granted, children being taken into care and rejection by families. Some patients were said (2) to become very frustrated and hence aggressive since they felt that nobody listened to them or understood their problems.

9.5.3 Interpersonal environment

A range of interpersonal strategies were deployed to prevent incidents during encounters with patients (5) and two CPNs attributed lack of incidents in community settings to high levels of interpersonal skills. The DNS said she regarded community nurses as the most skilled members of the nursing workforce in recognising the potential for violence in a situation.

CPNs stressed the importance of really listening to patients so that they knew they were being heard (2) and that the CPN could become attuned to their feelings (1). Recognising that one was a guest in patients' homes (2) meant not adopting authoritarian approaches (2). For another it was a question of being aware that raising certain subjects might provoke aggression:

> *'You become aware that this is not a good thing to discuss right now at this point.' (CPN 5)*

As noted in Section 9.5.1, having information about patients was regarded as important for staff safety. Nonetheless, knowledge that patients had a history of violence meant that CPNs might expect violence; their fear might then be transmitted to patients and elicit a violent response (1):

> *'I also feel that as care workers, if you have all this information that this person's very violent you're actually going in prepared for either flight or fright. And you can actually excite a person into becoming violent. That's how I view it.' (CPN 4)*

Ethnic group was identified as a factor (2). A West Indian CPN had been subjected to racial abuse from white relatives angry that the patient had not been allocated a white

CPN. This CPN had also been verbally abused by a black patient who wanted to be seen by a white CPN. A white CPN commented:

> *'They're angry. If you represent authority too - they may think if you walk into an estate which is two-thirds black and they think that they have a raw deal and you represent authority and you're white.' (CPN 7)*

Contrasting views emerged about appropriate body language during patient encounters (2). One CPN said it was important not to appear vulnerable:

> *'If you come across as vulnerable I think you leave yourself open, you are more vulnerable. I think it's important if you sense that a patient might be slightly hostile, and I think lots of people are - [since] they feel that society or their loved ones have let them down - you actually need to create a good strong situation: the way you sit etc. Be firm, be consistent and be clear.' (CPN 3)*

Another also felt that sitting with an open body posture indicated vulnerability but felt that this actually lessened the likelihood of violence.

9.5.4 Programme of care

i) Nature of treatment

Some aspects of CPNs' interventions were regarded as the cause of aggression (3). Although most patients were now informal admissions, one CPN said that people still saw psychiatric hospitals as places in which people were locked up and perceived that the visiting CPN had the power to have you 'put away'. In this CPN's view, the resulting fear and anxiety led patients to react aggressively. Some patients became angry and then aggressive when certain interventions were suggested (2): attending behavioural therapy sessions; having an injection; and being assessed by medical staff.

The nature of certain programmes was such that interviewees (2) stressed the importance of discussing that nature with patients at the outset, otherwise unexpected emotions might be evoked that could lead to violence. The CPN who provided behavioural therapy sessions said that when these attempted to deal with unresolved grief, the pain to which the patient was exposed provoked a great deal of anxiety and this in turn was manifested by aggression. She therefore informed patients referred for grief resolution therapy that the process could be quite painful and insisted that patients signed an agreement to say that they would not withdraw from the treatment, attack her

or the furniture in the office during sessions. or attempt suicide. Likewise a CPN who undertook counselling sessions said it was important to establish that patients understood what these involved and what they could and could not do during their course.

ii) Staffing

Although there was a policy that two staff should go on crisis calls, the nurse manager said there was insufficient staff to implement a policy of visiting in pairs when there was concern about violence. It was left to the discretion of individual CPNs to ask to be accompanied if they felt uneasy about visiting a patient alone. Five of the six women said that if they had concerns about violence they would ask a colleague to accompany them. As one of them put it:

> *'If there's any query about aggression you make certain that you don't go there on your own, you go in pairs .' (CPN 1)*

However, it was often difficult to get in contact with another CPN at short notice since they were dispersed district-wide (2). When patients were informed that two CPNs would be visiting and said that they only wanted to see one, arrangements were made for them to be seen in a CPN's office rather than at home.

Three interviewees discussed problems occasioned by visiting in pairs. Two women said that this was in the interests of staff safety; one observed that it was inhibiting for the patient and the other thought it signalled to the patient that they might be expecting trouble. and this in itself was sufficient to generate violence. This latter view was also held by the male interviewee who for this reason preferred visiting alone since it indicated to the patient that he was the person who was vulnerable:

> *'Even if we had the resources, even if it was a rule, I would break it, I would do it alone. Because I just know it's safer to do it that way.' (CPN 6)*

Interviewees (2) who saw patients in offices spoke about ensuring that other staff were sufficiently near to hand to be called to provide assistance if required. One CPN observed that the continuity she provided when running a clinic single-handedly meant

that patients knew her well. and if a patient attempted to assault her she felt sure other patients would come to her rescue.

iii) Providing patients with information

Emphasis was placed on CPNs keeping patients informed about arrangements (3) since this was said to lessen the likelihood of hostility when they met. If a decision was made for two people to visit, patients were informed beforehand (1). When patients were referred for behavioural therapy, the CPN always notified them about the referral before making a first visit (1). Patients receiving injections were informed when the CPN would visit for this purpose (1). Incidents were cited when patients had not been informed of intended actions and aggression had ensued (2). Awareness of information previously given to patients was advisable since confusion resulting from conflicting information could lead to incidents (1).

The CPN who specialised in behavioural therapy said she had often received referrals from general practitioners but on making contact with patients found that their GP had not informed them of the referral. On such occasions she had sometimes been met with hostility and verbal aggression, although not physical violence. Consequently, she now always made contact by phone or letter prior to an initial visit. She cited a recent example of the importance of prior contact:

> *'Just recently I was asked to see an agoraphobic man. The GP obviously had not really discussed it with the patient before referring him to me. I sent off a letter saying I would be calling round on such and such a day and then got quite an hysterical phone call saying "Do not visit this man", it was either from his wife or daughter: "If you visit him all hell will break loose and I cannot tell you what will happen so don't visit him". So if I hadn't been cautious enough to write a letter and I'd just turned up, that could have been a situation which may well have provoked aggression or violence.' (CPN 5)*

9.5.5 Preventative strategies when travelling to and from patients' homes

CPNs not only had to contend with the possibility of incidents involving patients but also with members of the public encountered while travelling to see patients. A range of individual strategies was described (5) and the question of visiting certain areas in pairs was discussed (4).

i) Individual strategies

Individual strategies included: not taking valuables (3): locking valuables in car (1): leaving car outside certain estates (1); carrying injections in a paper bag to look like shopping (1): and taking nursing stickers off cars so as not to advertise the fact that drugs might be inside (1). Two said that they avoided visiting after dark with one adding that she always went to certain estates in the morning as she felt safer at that time. However, the latter CPN said this posed difficulties for the service in that some patients needed an injection in the evening after work.

ii) Visiting in pairs

Some (4) said that CPNs should always go in pairs when visiting estates with a reputation for violence from residents, irrespective of whether violence was anticipated from the patient. Although staff had an informal agreement of accompanying colleagues when asked, three maintained that this should be health authority policy. The nurse manager said, however, that there was insufficient staff to cover existing workloads, let alone allocating two CPNs to one visit. Over lack of funding for sufficient staff to be able to visit in pairs, two CPNs contrasted their situation with that of other health professionals whose employing organisations had made provision for visiting these estates in pairs, including health visitors, social workers, postmen and the police:

> *'I don't know if we're in this situation because we are not valued or they think we can probably cope with it, or it doesn't really matter - I'm not quite sure which.' (CPN 7)*

9.6 MANAGING VIOLENCE

All interviewees discussed managing incidents.

9.6.1 Primary management

i) Interpersonal skills

Interviewees (5) described interpersonal skills used in trying to calm down patients whom they perceived as becoming aggressive. Encouraging patients to clarify the source of their anger enabled CPNs to help patients start dealing with the problem (3). One added that he told patients they were making him anxious and asked them why they

were behaving in such a way. He said that putting tension in the atmosphere into words defused it and enabled patients to start discussing the problem. Another said:

> *'If there's some anger around, rather than letting them bottle it up to the very end when they might explode, [it is wise] to acknowledge it in the early stages and maybe work with it so they're able to get it out in other ways.' (CPN 3)*

Other strategies included: making it clear that one would leave if the patient did not calm down (2); maintaining an open and relaxed body language (1); keeping very calm (1); and, in one incident, telling the patient about her own problems (the CPN).

Skills in recognising and managing aggression were described (3). Aggression was defused by letting patients know CPNs were really concerned about their problems (2), one adding that they then knew there was no need for them to be aggressive towards her and the other commenting that this made patients feel secure which, in turn, lessened the likelihood of escalation.

ii) Programme of care

When patients became aggressive during grief resolution sessions the CPN said she showed patients the contract they had signed at the start of treatment and reminded them of the agreement not to attack her. She added that although patients had banged the desk and torn up the contract none had physically attacked her. On some occasions when patients became aggressive during a home visit, CPNs encouraged them to agree to a hospital out-patient visit (2).

9.6.2 Secondary management

Interviewees (6) who had experienced situations in which they had been unable to calm patients down described their subsequent actions.

i) Summoning help

Interviewees who saw patients in offices (3) all spoke of the need for panic buttons that would enable them to summon help immediately. Two described incidents that had made staff recognise their vulnerability without such a system (one of these is included in Section 9.11.2). Although the offices had telephones, one observed that telephoning

for help when in an office with a patient who was becoming intimidating could transmit the CPN's fear to the patient and this had the effect of exacerbating the situation (1). The other commented:

> *'There's a telephone but that's not much good if someone's wielding a stick at you.' (CPN 5)*

Panic button alarm systems had been requested but none had been installed in nurses' offices at the time of fieldwork. This occasioned one CPN to comment that nurses were not valued in contrast to medical staff who did have panic buttons in their offices.

ii) Restraint

Physical restraint techniques were not used in managing violence in community settings. Such techniques were unnecessary if incidents were handled properly (1) and had to be regularly practised in order to be effective (1).

iii) Leaving the situation

All said that they attempted to leave the situation as quickly as possible. In patients' homes, they recounted using interpersonal skills to persuade patients to let them out (1), locking themselves in a room while parents of a patient who had hit out tried to calm him down (1) and retreating down the stairs while being shouted at constantly (1). The last incident is described in Section 9.11.1. On occasions when CPNs had told patients they were leaving because their level of aggression was preventing progress, patients had calmed down and asked them to stay (2). Leaving sessions in offices when patients became angry included getting out at the first opportunity and calling for help (1) and deciding that patients were best left alone for a while (2):

> *'You're better to go out and let them beat hell out of the cushions until they've calmed down. The last thing I think you should do is go up and tap them on the shoulder and say "Look I don't think you should do that - calm down" - good sense tells you they're not hearing you.' (CPN 3)*

Counselling relationships that were perceived as becoming a threat to CPNs' safety were ended (2).

iv) Involving other professionals

Having escaped from a situation, CPNs alerted other professionals as appropriate. In some instances this involved visiting again accompanied by a male CPN (1) or asking a male CPN to make the next visit (1). In other circumstances, the expertise of different professionals was called upon. A visit from the patient's GP, or from a GP and a social worker, was requested to assess whether the patient should be admitted to hospital (2). Patients were discharged to their GP once the CPN had concluded that further visits from CPNs would bring no benefit (1). Police were called to remove patients from healthcare premises (1); such an incident is described in Section 9.11.3.

9.7 POST-INCIDENT EVENTS

9.7.1 Discussing incidents

Although incidents in community settings were infrequent, interviewees (7) referred to post-incident discussions.

i) Discussion with other CPNs

When incidents occurred in patients' homes, CPNs did not usually have colleagues to hand with whom these could be discussed. Such opportunities were available subsequently, however, either upon returning to the CPNs' office (2) or at the weekly meeting for all CPNs (6). One described how constructive criticism at the weekly meeting of his approach had helped him recognise how it had contributed to generating aggression.

Although all (7) said that CPNs did discuss incidents, four also felt that more discussion was needed, with two offering reasons for reluctance. While one attributed reluctance to fear of being blamed for having provoked the incident, the other attributed it to fear of losing face:

> *'People ought to be encouraged to talk about it ... [so] that people won't lock it away and feel either if they do fall apart or if they are feeling extremely sensitive to it, that they're not coping, [so] that in fact it's a very good thing to actually bring it out into the open. And until we do it's going to be a difficult area.' (CPN 3)*

ii) Discussion with patients

As hospital admission was the likely outcome when CPNs left situations in which they felt that patients had become too aggressive for the encounter to continue. CPNs did not often have opportunities for post-incident discussions with patients. Circumstances when such discussions did occur included: ringing the patient for a discussion having returned to the CPNs' office (1) and, when an incident had occurred elsewhere, going to the patient's home with a colleague to learn about the incident from the patient's perspective (1).

iii) Discussion with nurse manager

Opportunities for CPNs to discuss incidents with their nurse manager included the monthly clinical supervision session (4). The nurse manager also offered individual counselling sessions for debriefing and support (1). Two staff contrasted these opportunities with the rather dismissive approach they had encountered in hospital where the approach taken after incidents had been:

> *' That's what you get your psychiatric lead for.' (CPN 7)*

iv) Discussion with other professionals

The CPN based at the community mental health centre said psychiatrists participated in meetings when incidents were discussed, and they pressed for alarm systems to be installed in every office.

9.7.2 Post-incident support

The nurse manager supported staff involved in incidents through the discussions described. Psychiatrists' concern for staff safety was illustrated by the CPN who worked in the community mental health centre. She recounted an incident committed elsewhere by one of her patients after which one of the centre's psychiatrists had said that he could not sanction further contact between the CPN and patient because of the danger involved. Lack of support from medical staff was instanced by a GP expressing anger with a CPN who had, on the nurse manager's advice, discharged a patient following an incident.

9.8 LEARNER NURSE PLACEMENTS

Learners' placements included accompanying a CPN on visits to patients and partway through the placement having a small caseload of their own. Patients were carefully selected to include only those assessed as very unlikely to be aggressive (3) and CPNs kept their learners' work with patients under close supervision (3).

Although patients had been selected for little likelihood of aggression, learners gained insights into strategies to adopt in this event through group teaching sessions in which problem situations were role-played and various approaches were identified and discussed (1). Advice to learners included keeping calm (1), not placing themselves in situations in which they thought they might be verbally or physically attacked (1), and if such an attack happened to leave immediately (1).

9.9 FEELINGS ABOUT VIOLENCE

Interviewees' (7) responses to questions on feelings about violence focused on: being at risk; encounters with patients (6); travelling to patients' homes (4); and a reluctance to think about the subject (2).

9.9.1 Staff safety

Community staff were regarded as being at risk (4) because of the unpredictable nature of mental illness (3):

> *'We are at risk in psychiatric services, because always there is the unknown quantity, the unknown element in the patient. You can't foresee everything.' (CPN 1)*

and because they were working in isolation without the support systems available in hospital (2):

> *'You are more vulnerable. And you are entirely on your own out there, there's nobody. In the institution you've got lots of support systems. And you haven't got any out there. I mean you have but you need to get to it.' (CPN 4)*

9.9.2 Feeling scared

Female interviewees, none of whom had been physically attacked while working in the community, described feeling frightened by patients (5). In some instances fear was occasioned by thoughts (3) that threats expressed verbally might be translated into action:

> *'With verbal aggression there is always the fear there that what if he actually comes and attacks me.' (CPN 1)*

Other frightening encounters entailed threatening gestures, such as making stabbing actions, throwing furniture and banging fists on desks (3). Two CPNs described instances in which fear was generated by possible outcomes of actions. The first instance entailed a decision by a consultant psychiatrist that a CPN had to discharge a patient on the grounds that the patient posed a threat to the CPN's physical safety. This decision occasioned other anxieties for the CPN; social workers would now have to visit the patient and be exposed to danger and, moreover, the patient might be angry with the CPN for rejecting her and 'come and get me'. In the second instance a CPN had felt that a patient whom she had been counselling had developed an unhealthy attachment to her and when he was discharged from her care threatened to kill them both. Although the CPN left the centre that the patient attended, she described feeling frightened for months afterwards. Feeling wary or worried (2), particularly when patients had a history of violence, was also reported.

The male CPN, who described several occasions when he had been physically attacked by patients in the community, said he was not afraid of physical violence:

> *'I'm not actually that frightened of people. If I think of someone hitting me, it's not a pleasant thought, but it's not something that I'm really frightened of quite honestly.' (CPN 6)*

Feelings when visiting areas with a reputation for violence were described by four of the female CPNs and included fear, nervousness, anxiety, stress, vulnerability, uncertainty and isolation. In the words of one:

> *'But I do feel very much at risk going in the lift - I won't get in the lift if I can help it. Going past groups of youths, I feel extremely anxious about -*

there are groups of people just hanging around looking menacing and I've felt I really don't feel like walking past them.' (CPN 5)

9.9.3 Not thinking about violence

Despite expressing views that there should be more discussion about violence, two women, both with years of experience, said that they preferred not to think about it. For one:

'And it is isolating and it is stressful and you tend not to want to think about it and be preoccupied by it, it would probably drive you insane. So you get on with it - but that's not good enough.' (CPN 3)

The other woman felt that as she became older she was less able to cope mentally or physically with violence. She said that she tried not to think about violence because, if she did, she would be too scared to visit certain of the housing estates in the district.

9.10 RIGHTS AND LEGAL POSITION

Community interviewees had much less to say than institution-based interviewees about the rights of patients and staff and the legal position of nurses. While one commented that there was a lack of clarity as to how much force nurses could use, another observed that legal problems associated with restraint were not relevant to community work since CPNs would not attempt to restrain in patients' homes.

9.11 INCIDENT EXAMPLES

Examples of incidents illustrate the points made in previous sections and include one in a patient's home and two in health service premises.

9.11.1 Verbal aggression in patient's home

i) Incident details

The CPN was visiting a patient to give her an injection. The CPN described the patient as 'huge' and having a 'threatening manner'. On previous visits the patient had repeatedly changed her mind about whether or not she would have the injection. On this occasion, on the CPN's arrival the patient had several changes of mind. Finally she said 'Oh come on then, you can give it to me'. The CPN then followed her to a room at the

top of the house and got out the injection but the patient then became very angry. saying 'I have no time for that'.

The CPN said to the patient 'If you don't want it that's OK with me'. and went downstairs. The patient followed her, shouting all the time. The CPN said:

> *'And I was afraid to look over my shoulder, I just kept going. I got out of the door and crossed the road to the car and she was still standing at the door shouting.' (CPN 7)*

ii) Subsequent events and reflections

The CPN reported the incident to her manager, who advised that the CPN should discharge the patient back into the care of the GP. The CPN said she did this but the GP was very angry with her because, in her view, he was afraid to visit her himself. The patient was subsequently admitted to hospital. The CPN said she was anxious both on her own account and on behalf of her colleagues, about the patient being referred back to the CPN service, since she felt that no one should be asked to visit the patient alone.

9.11.2 Patient behaving aggressively when alone with CPN in office

i) The incident

The CPN had an appointment with a patient at the health centre. The patient entered the office and started banging his fists on the desk. He then shouted, screamed, threw objects about and demanded money from the CPN. The CPN said she was very frightened but tried to keep calm. She felt that if she phoned for help it could make the patient more aggressive, so she decided to try and leave the office. When the patient moved to the end of the room furthest from the door she slipped out.

ii) Subsequent events and reflections

The patient stayed in the office throwing objects about; the police were called and escorted him off the premises. The CPN said that they were very at risk alone with patients in offices. At a subsequent meeting of health centre staff it was agreed that social workers and psychiatric nurses should have a panic button installed in their offices so they could summon help in such events. The GPs already had panic buttons in their offices. The incident had occurred three years previously and buttons had not yet been installed.

9.11.3 Patient becoming aggressive in reception areas of premises

i) The incident

The community mental health centre had a drop-in policy and the centre secretary had let in a patient who had attended several times previously and invited him to sit down while she called the duty worker. Before the duty worker arrived the CPN noticed the patient and that he was pacing up and down. She asked his name and whether she could help him, and he became very verbally aggressive. Becoming aware that he was also very agitated and feeling concerned that he might become violent, she decided to take action and not wait for the duty worker. She said:

> *'His whole attitude was one of aggression, my sense was that this man is heated up - he's come here and he's raring to go.' (CPN 3)*

The CPN found the patient's notes and rang the duty worker asking her to come immediately to talk to the patient. The notes indicated that the patient had a range of social problems and had assaulted members of the social work team and members of the public. The duty worker came to the reception area and tried to calm the patient down. The CPN kept her distance since she felt that if they both approached the patient he might feel threatened and become more aggressive. She kept him in her view, however, so she could assess what was happening and told the secretary that if she said 999 to telephone the police immediately.

ii) Subsequent events and reflections

Although the patient eventually calmed down and left the centre, the incident focused staff concerns on how potentially vulnerable they were if patients became aggressive on the premises. It was not always possible on opening the door to assess whether a patient would become aggressive; if one did, then an incident might occur in the time it took to contact the local police station and for the police to arrive. Staff decided they needed an alarm system that linked directly to the police station, the health authority agreed and, at the time of the interview, the installation of such a system had just been costed.

9.12 OVERVIEW

Focusing on community psychiatric nurses who provided a range of services, this chapter has provided a detailed account of their views and experiences in relation to violence. The incidence of violence involving patients was rare; the possibility of violence from members of the public while visiting patients was perceived as a greater problem. Only one CPN had been assaulted, the others had all felt anxious on occasion about the possibility of assault. This final section draws together interviewees' perceptions of factors that had a positive impact on the ways in which they were able to relate to violence and those that had a negative impact.

Positive factors included: staff skills and experience; post-basic education opportunities; regular meetings with colleagues when expertise could be shared; supportive psychiatric medical staff; and willingness of colleagues to come to each other's assistance in health service premises and to accompany each other on visits when there were concerns about violence. One interviewee differed from the others in deciding always to visit alone.

Negative factors included general practitioners failing to inform patients about plans for their treatment and failing to provide CPNs with information in referral forms about violence in a patients' histories. Other negative factors included insufficient staff to implement a policy of visiting certain estates in pairs, and a lack of panic buttons in offices to summon help unobtrusively.

CHAPTER 10: DEVELOPING CATEGORIES ACROSS SETTINGS

This chapter moves beyond the findings for the six separate settings, presented by the dimensions of the conceptual framework, in the previous four chapters. As described in Sections 5.8.2 ii) and 5.8.3 ii), seven substantive categories were developed from the findings for each setting. These were then developed across the settings as a whole (Section 5.8.4 i)) and this chapter presents the outcome of this analysis (Section 10.1). Each category had several properties, most of which were concerned with strategies to support nurses in their role and strategies to reduce violence and better manage that which occurs. When findings contributed to the development of more than one property, a cross-reference is provided in the text.

The cross-settings analysis of the various personnel and organisations identified as responsible for the implementation of these strategies (Section 5.8.4 ii)) is presented in Section 10.2.

For ease of reading, the following additional abbreviations are used in this chapter: CCMS for continuing care, medium-stay; CCLS for continuing care, long-stay; LW for locked ward; DNS for Director of Nursing Services; ADNS for Assistant Director of Nursing Services; SNO for Senior Nursing Officer; and NO for Nursing Officer.

10.1 DEVELOPING CATEGORIES ACROSS SETTINGS

The categories and properties developed across the data set as a whole are shown in Figure 10.1. The following account includes reference to the policy and research literature that influenced the development of these categories.

Figure 10.1: Categories and Properties

1. Appropriateness of placement
1.1 Appropriately placed
1.2 Appropriate but unable to be placed
1.3 Appropriate initially but not currently
1.4 Inappropriately placed

2. Knowing what to do
2.1 Experience and observation
2.2 Theoretical teaching
2.3 Working as a team
2.4 Documentation

3. Willingness to discuss
3.1 Discussing patient care
3.2 Discussing incidents

4. Feeling valued
4.1 Valuing nurses' views
4.2 Others not fulfilling their role
4.3 Valuing nurses through resource provision

Setting
Nurse in charge
Nursing staff
Patients

5. Being supported
5.1 Willing and able to support
5.2 Willing but unable to support
5.3 Not willing to support but having to do so
5.4 Not willing and not supporting
5.5 Not recognising that support needed

6. Judging responses
6.1 Patients' perceptions of nurses' expectations and intentions
6.2 Patients' perceptions of nurses' actions over staffing levels
6.3 Nurses' perceptions of patients' responsibility for violence
6.4 Nurses' perceptions of other health professionals' interpretations of actions

7. No win situations
7.1 Staff safety versus patients' rights/needs
7.2 Meeting staff safety versus causing patient aggression
7.3 Either action having adverse outcomes
7.4 Staff safety ensured through one action causing other dangers to staff

10.1.1 Category 1: Appropriateness of placement

Category 1 is concerned with nurses' perceptions of the appropriateness of placement of patients in relation to violence. The development of this category was influenced by policy debates and developments about the placement of patients (Sections 2.4 and 2.7) and showed how these translated into relationships between different professional groups and between nursing staff in the different settings. The category had four properties: appropriately placed; appropriate but circumstances prevented admission; initially appropriate for admission but changed circumstances meant that now inappropriately placed; and inappropriate for admission from the outset.

i) Property 1: Appropriately placed

In all settings, most patients were regarded as appropriately placed. On the locked ward, appropriate patients included: those admitted from the community in acute phases of a psychotic illness; some of those transferred when too aggressive for other settings in the hospital; and those transferred from more secure environments as no longer requiring that level of security. On the continuing care, medium-stay ward (CCMS), appropriate patients were those able to benefit from a programme focusing on recovery from mental illness. On the continuing care, long-stay ward (CCLS) appropriate patients were those able to benefit from a programme of rehabilitation. In the two rehabilitation settings, appropriately placed patients were those well enough to benefit from programmes of developing skills for community life. In community settings, appropriately placed patients were those who could be supported at home and those who would benefit from specialist services such as counselling, behavioural therapy and self-referral drop in centres.

ii) Property 2: Setting appropriate but patients unable to be referred or retained

For three settings, patients were identified for whom placement would be appropriate but various factors prevented admission. On the locked ward (LW) and CCMS there was occasionally no space for others suitable for admission, sometimes because places had been taken by inappropriately placed patients. Patients whom community psychiatric nurses (CPNs) regarded as suitable were sometimes not referred to the service since medical staff regarded them as posing too great a risk to CPNs' safety. Occasionally CCMS interviewees would have preferred to retain their own patients but lack of staff and/or skills in managing aggression resulted in transfer to the locked ward.

iii) Property 3: Placement initially appropriate but not currently

a) Patients needing transfer to a different setting within the hospital. On both continuing care wards, there were occasions when staff thought patients should be transferred to the locked ward but they had to remain since it was already full. Likewise in both rehabilitation settings, relapsing patients were sometimes unable to return to their continuing care ward since their place had been taken, usually due to loss of beds through the ward closure programme. In these settings therefore, staff had to manage a greater level of aggression than that for which they felt resourced. Having been transferred to the locked ward, patients were not always able to return to their own ward once ready and wanting to do so and sometimes expressed their anger against the locked ward staff. Constraints on return included staff being unwilling to accept their return or their place having been taken by another patient.

b) Patients needing transfer to a setting outside the hospital. Some patients subsequently became too dangerous for the locked ward staff to care for and although nursing and medical staff requested their transfer to a secure unit, this often took time to implement because of pressure on secure unit places and what was perceived as these units' highly selective admission criteria. On CCMS there were patients whose aggressive behaviour was such that staff felt that they should be discharged but were unable to secure agreement for this to be implemented.

c) Patients needing transfer from care of community psychiatric nurses. Although community nurses were able to transfer patients who relapsed to the care of other staff, this sometimes occasioned concern for the safety of these staff.

iv) Property 4: Patients inappropriate for admission

Some patients were regarded as inappropriate for admission from the outset.

a) Too aggressive for the setting. Some locked ward patients were regarded as too dangerous for nurses to manage and so importance was accorded to the nurse in charge opposing proposals for such admissions. Patients recently transferred to the CCLS ward without discussion with ward staff, were regarded as more disturbed than resident patients and increased the overall level of incidents. Although nurses in rehabilitation

settings were included in multidisciplinary teams that made admission decisions. nurses' views that certain patients were unsuitable because of aggression were sometimes overruled due to pressures of the ward closure programme.

b) Treatment needed not available. Views differed among LW and CCMS interviewees over whether patients diagnosed as having a personality disorder were mentally ill, although all agreed that appropriate treatment programmes were not provided by the hospital. LW interviewees felt likewise about patients admitted in a drug-induced psychosis on a Section 136 of the Mental Health Act. Both groups of patients, however, were regarded as those most likely to be involved in violent incidents. Admitting these patients overrode nurses' views about availability of suitable treatments and whether they had resources to manage likely levels of aggression. LW and CCMS interviewees identified other groups of patients whom they thought unsuitable for admission. The settings could not provide the treatment these patients required and although not aggressive they took up time that staff felt could have been better spent with others.

c) Intruders. Rehabilitation staff had to contend with aggression from people other than the patient group for whom they were caring. They included patients who had been discharged from the setting and intruders. Although security staff were available to effect the removal of intruders, they often took time to arrive. Moreover, some of these outsiders were unknown to staff and so they had to manage aggression without necessarily knowing the best approach to adopt.

10.1.2 Category 2: Knowing what to do

This category focused on the sources from which nurses gained knowledge and skills in relation to aggression and violence. Four properties emerged: experience and observation; theoretical teaching; working as a team; and written documentation. The development of this category was influenced by other research on the experiences of student nurses (e.g. Melia 1987) and newly qualified staff nurses (Lathlean *et al.* 1986) and by the emerging findings from the learner nurse project. The category developed in this study included interviewees' perceptions of their student experiences in relation to how they 'knew what to do' but also to many facets of their work as qualified nurses.

i) Property 1: Experience and observation

a) Student placements in settings in which violence likely to occur. Student placements in acute settings, usually including a locked ward, had been the norm for most interviewees and this, combined with support from service staff and observation of their practice, was regarded as a positive initial grounding in knowing how to prevent and manage violence. Occasionally this experience had negative aspects, such as advice from teaching staff contradicting that given by service staff and lack of support from the latter. Acknowledged benefits of their own locked ward student experiences lay behind staff criticisms that students at the site no longer had such placements. The three senior nurse managers and the NOs for institutional settings all thought that students should have a locked ward placement. Constraints included opposition from the English National Board over consultant numbers, tutorial staff disliking locked wards and staff preferring not to have students in their setting.

b) Experience as a qualified nurse. Skills in relation to violence came primarily from experience and observing others during acute care posts or, as at the study site, a staff nurse rotation scheme now no longer operational. Experience underpinned confidence in judging how best to handle situations both as the nurse in charge and as a shift member. Some rehabilitation staff had no acute care experience. Some interviewees, including the DNS, felt that the existence of the locked ward had militated against staff in other settings maintaining skills in managing incidents although staff on open wards were now being encouraged to manage their own patients.

c) Effect of lack of experience. Lack of acute care experience among hospital staff as a whole led the ADNS and the night-duty SNO to observe that they were finding it difficult to staff acute wards. Although violent incidents were rare in the two rehabilitation settings, both CNs were concerned about the inexperience of junior staff since they did not recognise that incidents were developing and so did not act to prevent them. When such recognition did occur these junior staff lacked confidence to handle them. A cycle of inexperience was identified with inexperienced staff nurses sending patients to the locked ward which, in turn, deprived students on those wards of experience.

ii) Property 2: Theoretical teaching

a) First level education. Interviewees' own nursing school education in relation to violence was perceived almost entirely negatively, mainly through lack of sufficient depth and through advocacy of approaches regarded as unrealistic in practice. While institutionally based interviewees were critical of the current approach adopted by tutorial staff on the site, the community manager welcomed its focus on interpersonal relationships. The DNS and the ADNS both commented on different approaches to violence used by current service and education staff and said that a new scheme was being implemented that should increase discussion between the two groups; contact which a CN said had once been the norm.

b) Continuing professional development (CPD). CPD relevant to violence included courses, clinical supervision and sharing expertise with colleagues. Some interviewees, mainly CPNs, had attended courses that had proved useful but most staff had not. Few courses were provided and short staffing sometimes prevented attendance. Night staff found it difficult to attend day-time courses and both the night-duty SNO and NO felt that a new approach was needed for their continuing professional development. Rehabilitation and community interviewees suggested that lack of courses was due to a reluctance to acknowledge that violence was a problem. Recently, arrangements had been made for all staff in acute settings to attend a Control and Restraint course and more in-service courses had been provided. The DNS regarded education of staff as the main means of reducing the incidence of violence.

Opportunities to learn through discussing incidents were available in some settings (also contributes to Category 3, *Willingness to discuss*, Property 2, Section 10.1.3 ii)) but only CPNs had opportunities to learn through individual supervision or debriefing sessions with their line manager. Learning from expertise of colleagues came primarily through discussion (also contributes to Category 3, *Willingness to discuss*, Property 1, Section 10.1S.3 i)). Although CPNs worked primarily by themselves, discussions at weekly group meetings provided opportunities to learn from others. There were also examples of gaining skills in physical restraint through teaching by other shift members (CCLS and day hospital).

iii) Property 3: Working as a team

For LW and CCMS interviewees, knowledge also came from familiarity with the working practices of a long-standing group of colleagues; this was described as knowing instinctively what to do when defusing incidents and employing restraint. Knowledge also emerged from team discussions (also contributes to Category 3 *Willingness to discuss*, Property 1, Section 10.1.3 i)).

Increasing use of agency staff on one LW shift, however, was identified as decreasing team effectiveness, since these staff did not always know what to do. In the two rehabilitation settings a team ethos had had less time to develop since most staff apart from the CNs were recently qualified. Perceptions of lack of team work also emerged amongst senior nurses. The NO for the CCMS ward had drawn attention to lack of decision-making between senior nurses and medical staff about the placement of patients involved in incidents and the DNS had decided that a more formal system of communication between the two groups was needed.

iv) Property 4: Documentation

Three types of documentation were identified as sources of guidance: patients' histories; guidelines; and the 1983 Mental Health Act.

a) Patients' histories. Having knowledge of patients' histories of violence was mainly regarded positively in that it could inform appropriate approaches. An alternative view expressed in all except the rehabilitation settings was that having such information might result in nurses approaching patients in a way that signalled violence was expected and patients responding likewise (also contributes to Category 6 *Judging responses*, Property 1, Section 10.1.6 i) and to Category 7 *No win situations*, Property 2, Section 10.1.7 ii)). In the main, interviewees felt sufficiently informed about patients' histories through reading case notes and records made by other members of the nursing team.

Negative instances in institutional settings included one LW shift where interviewees felt the CN failed to ensure that all staff had relevant information about patients. The ADNS held that part of the problem was staff not updating care plans often enough. Most concern about lack of information came from CPNs, in particular that GPs did not

provide them with sufficient information on referral forms about patients' potential for aggression (also contributes to Category 4 *Feeling valued*. Property 2, Section 10.1.4 ii) and Category 7 *No win situations*. Property 2, Section 10.1.7 ii)).

b) Guidelines. Although local guidelines existed, there was little sense of this being an actively used document in institutional or community settings. In some settings, views differed over whether such a document existed. Those who had read the document described it as unrealistic and lacking depth. The DNS stated that guidelines were not reviewed often enough and planned to review the current ones shortly. While interviewees thought that guidelines could be improved if practice staff were involved in their development, they also acknowledged that current guidelines were useful for students and newly qualified staff. Experienced interviewees commented that each situation was unique, requiring individual judgement rather than following prescribed courses of action. When deciding how to handle situations they drew on experience and assessment of situations rather than guidelines.

c) The Mental Health Act 1983. LW and CCMS interviewees expressed concern that the Act lacked clarity over use of self-defence if attacked, what constituted minimum force, and what protection was afforded to nurses accused of injuring patients during restraint. The last point was cited as contributing to nurses hesitating after having decided that restraint would be the best course of action.

10.1.3 Category 3: Willingness to discuss

This category concerned willingness to discuss violence and had two properties: discussions to formulate care plans for patients with a view to preventing violence; and discussion of incidents. It focused on variations in willingness to discuss and on reasons offered for willingness or its lack. Development of this category had several influences: recommendations in guidelines about the importance of discussing incidents (Section 2.2.1 ii); findings from the learner nurse project about the importance some accorded to post-incident discussion; and previous research (Section 3.7). The notion of variation was influenced by Glaser and Strauss's theory of open and closed awareness contexts for care-giving that had been developed from research with dying patients (Glaser and Strauss 1967).

i) Property 1: Discussing patient care

There was a continuum across the settings, from willingness to formulate care plans to a lack of willingness to do so. The most positive instance of this property was afforded by staff on the two CCMS shifts, all of whom reported regular discussions to this effect. Such discussions meant all staff knowing which approach to adopt, thus achieving consistency of action, even though individuals' views about causes of violence might differ. The CCMS night staff held informal discussions when not busy.

A more diverse picture emerged from other settings. Some CPNs said that they discussed approaches to violence when formulating patients' care plans, whereas others said violence was only discussed when incidents occurred. Constraints included violence being too difficult a subject to confront, some interviewees indicating that if it was discussed they would become too scared to undertake their work and could only cope by not thinking about it. On the locked ward positive instances included discussions at handover about patients over whom there was concern in relation to violence. Discussions between qualified staff on the CCLS ward were limited to handover since only one qualified member of staff was on duty. One NA on this ward reported that the SN discussed violence with him; the other felt that the CN ignored his views.

Such discussion was lacking in both rehabilitation settings. Constraints included staff inertia and staff avoidance of the subject. Interviewees were critical of themselves as well as of others, acknowledging that nothing prevented them having such discussions. Lack of cross-shift discussion was criticised by LW interviewees in relation to greater use of restraint and seclusion on one shift and by CCMS interviewees over developing consistent patient care policies across shifts.

ii) Property 2: Discussing incidents

a) Discussions between staff. Incidents were discussed in most settings: two of the three LW shifts; all the CCMS shifts; all the rehabilitation shifts; and in the community at office bases and weekly staff meetings. Interviewees in all settings described benefits as improving approaches to preventing and managing violence. Other benefits included restoring staff morale (LW) and recognising the need for action to reduce staff vulnerability in certain situations (day hospital). Discussions between members of

different shifts about incidents and subsequent care plans took place at handover and were nearly all reported as positive in that the next shift took note of the recommendations of the last. Incidents occurring in people's homes and in community premises were discussed with colleagues at subsequent meetings.

Negative instances included having too few discussions or even none at all, and their quality being poor. Constraints included reluctance by one of the locked ward day shift CNs, and having only one qualified person on the CCLS shifts. The quality of discussion was described by a rehabilitation hostel interviewee as gossipy rather than a critical analysis of events. Many who said discussions were held also said that their frequency should be increased. Constraints included fear of being criticised for provoking incidents or for incompetent handling (LW, CCMS, rehabilitation hostel and community). Other constraints identified by LW interviewees included: finding the tone of meetings difficult; familiarity, such that nothing more could be learnt from discussion; the view that certain incidents were not preventable; and reluctance to revive painful memories of one's own violent behaviour. The NA in the rehabilitation hostel stated that discussions made no difference and were pointless.

The ADNS said he liked to think that staff did discuss incidents while the DNS thought that if they did, then it was only briefly. She regarded discussions as an important means of expressing and dissipating feelings of anger towards patients. For the night-duty SNO, the ideal situation would be the opportunity to discuss incidents with someone outside the setting since this would be more likely to facilitate constructive criticism.

b) Discussions with nurse managers. Diverse views emerged over whether nurse managers were involved in post-incident discussions and whether their involvement was desirable. In some settings views differed between interviewees and their nursing officer about the nature of the latter's involvement. The community manager was the most involved since she held weekly staff meetings and provided individual clinical supervision and debriefing sessions in which incidents could be discussed. Managers came to the LW and CCLS night shifts and the rehabilitation hostel for some post-incident discussions but were not reported as doing so on the LW and CCMS day shifts.

Constraints included the view that setting staff could handle discussions themselves and a lack of willingness by some staff in the hospital for expertise to be shared.

c) Discussions with patients. Views differed between LW shifts about whether discussions were held with patients whereas, in other settings, views differed within shifts. Benefits included ascertaining patients' perspectives on why incidents happened and considering with them how these might be prevented. Constraints included patients having no idea why incidents occurred, being reluctant to discuss them and not taking discussions seriously.

10.1.4 Category 4: Feeling valued

This category focused on nurses feeling valued and had three properties: consideration by others of nurses' views about violence; others failing or being unwilling to fulfil their role resulting in violence towards nurses; and provision of resources to facilitate prevention and management of violence. The development of this category had several influences: concerns that mental health services have been accorded a lower status than many other services and that this is reflected in a lower level of resource allocation (e.g. Brooking 1985); the literature concerned with the traditionally subservient role of the nurse to that of the doctor (e.g. Mackay 1989, Wicks 1998); and recommendations in guidelines that staff involved in incidents should be supported 'when acting in good faith' (Section 2.2.2 ii)).

i) Property 1: Considering nurses' views about violence

Four aspects of care-giving emerged from interviewees' accounts of whether others considered their views.

a) Context of care delivery. LW interviewees identified three changes about which they felt they should have been consulted. First a change in ward design that was experienced as conducive to violence. Second, changes in arrangements for assessing patients admitted under a section 136 that meant the nurse waiting with the patient was now separated from other team members while awaiting medical staff. Third, changing from one consultant to several having responsibility for locked ward patients that occasionally resulted in too many patients being placed in the ward and which, in turn,

contributed to violence. Rehabilitation hostel staff were critical of nurse managers allowing non-residents to use the hostel canteen.

b) Admission of patients. Nurses' views being taken into account over placement was included in Category 1 *Appropriateness of placement* (Section 10.1.1) but also contributed to the present Property, *Considering nurses' views about violence*. Most patients were regarded as appropriate for the settings to which they were referred, and medical staff had recently been considering nurses' views more than hitherto. Instances of health professionals not considering nurses' views, however, occurred in all settings. Medical staff did admit some patients whom nurses regarded as inappropriate because of their level of aggression. In contrast, consultants sometimes refused to refer patients to the CPN service on grounds of dangerousness, whereas the community manager thought that these patients should be referred. Nurse managers were criticised for moving long-stay patients without consulting ward staff. In multidisciplinary rehabilitation meetings, nurses' views about the suitability of certain patients for admission were sometimes overridden.

c) Patient treatment. Positive instances included nurses valuing each others' views through constructive discussion, and each shift being receptive to patient care recommendations made by the previous shift (also contributes to Category 3 *Willingness to discuss*, Property 1, Section 10.1.3 i)). Negative instances included some CNs not being receptive to ideas proposed by junior staff or by NAs, and some day shifts not being receptive to views of night staff. Views about medical staff taking note of nurses' views when making decisions about patients' treatments varied. Those who were critical felt that views of those who knew patients best (i.e. nurses) were not valued.

d) Incidents. Other health professionals were described as not valuing the views of nurses involved in incidents, with the exception of the team based in the community mental health centre. Interviewees in all institutional settings said nurse managers believed patients and not nurses when accounts differed. Consequently nurses feared that managers would be unsupportive if patients alleged assault, although none had experienced such a situation. Medical staff responsible for the LW and CCMS ward attributed all violent incidents to mental illness rather than to antisocial behaviour, even when nurses who had been present thought otherwise. In this context, the DNS

observed that understanding why incidents occurred required observation of all preceding interactions and such observations were more likely to be made by nursing than medical staff. The DNS and ADNS thought that medical staff were unaware of the level of violence encountered by nurses.

Tutorial staff spoke directly to nurse managers when students placed on the CCMS ward expressed concern about staff actions during restraint rather than first talking with ward staff, the latter then having to defend their position to their nurse manager. Some LW interviewees referred to similar situations when describing previous student placements.

ii) Property 2: Others failing or being unable to fulfil their role

This property concerned instances when others were unable or unwilling to fulfil their role resulting in aggression against nurses. Once a decision had been made that the next step in the care of an aggressive patient was intervention by other staff, nurses still had to provide care in the interim with their own resources. LW staff had to wait with patients admitted on a section 136 between the police leaving and the doctor arriving to make an assessment. CC ward staff had to contend with aggression from patients angered at delays in being able to speak with their doctor. Rehabilitation staff had to cope with aggression with inadequate resources when there were delays in the arrival of other nurses to assist, medical staff to agree a transfer or change of medication, and security staff to remove intruders.

Many instances in this property concerned medical staff failing to provide information. This included GPs not informing CPNs about patients' potential for violence and CPNs then facing aggression from these patients when they unwittingly made inappropriate approaches (also contributes to Category 2 *Knowing what to do*, Property 4a), Section 10.1.2 iv)). GPs were also criticised for failing to inform patients about treatments that they had asked CPNs to provide. Consequently, patients were angry with CPNs when the latter contacted them to make arrangements. In institutional settings, lack of information was manifest in psychiatrists not discussing patients' treatment with them and patients then becoming angry with nurses when the latter explained what was planned (LW and CCMS).

iii) Property 3: Nurses feeling valued through provision of resources

Interviewees described feeling devalued when resources to enable them prevent and manage violence were lacking. While inadequate resources resulted from financial and policy decisions made by senior managers in the hospital and health authority, it was nurses who suffered the consequences when deficits contributed to generating violence.

a) Resources to prevent violence. Resources referred to included staff, equipment and materials for activities, space and food. Two interviewees (LW and CCLS) regarded nurse staffing as sufficient to keep patients occupied although the latter added that the nurse in charge did not deploy staff effectively. All other interviewees, apart from the CNs in the two rehabilitation settings, were critical of staff numbers. Thus, most LW and all CC interviewees said staffing was insufficient to prevent patient boredom that contributed to violence. On the CCLS ward, staffing was such that often no one was near enough patients to witness and defuse incidents. Both rehabilitation CNs said that while staff numbers were sufficient all staff, apart from themselves, were recently qualified and too inexperienced to recognise imminent violence and take preventative action. Community staffing levels were insufficient for visiting certain estates and patients in pairs to be routine policy. Since this was policy for all other health and social care professionals working in the area, including the police, some interviewees felt this indicated that nurses were not as highly valued. In all settings, interviewees described requests for more staff that were not met, although some observed that nurse managers could not provide staff that they did not have.

All comments made about other resources were critical: insufficient equipment and materials for activities on the LW and both CC wards; insufficient places in therapy departments for patients on the CCMS ward; inadequate space for activities and insufficient food on the LW; and a lack of occupational therapists to contribute to the programme of activities (LW and day hospital). Each of these factors was regarded as contributing to incidents occurring.

b) Resources to manage violence. Resources included staffing, space, skills in restraint, alarms and security staff. In all settings, incidents occasionally required additional staff but interviewees on the LW and CCMS night shifts felt that nurse managers allowed staff numbers or mix to reach the point when incidents that should

have been managed without assistance could not be. Nonetheless managers did send extra staff when requested for emergencies and at night some came to the ward themselves. Lack of space on the LW made it difficult to manoeuvre patients safely and the narrow doorways had occasionally caused staff injury. Lack of skills in restraint led an LW interviewee to observe that incidents were not well managed and CNs in both rehabilitation settings said that this constrained the range of patients who could be admitted.

Lack of progress in providing alarms for summoning help quickly and unobtrusively, even when the need for these had been agreed, was attributed to nurses' safety not being valued. Such instances came from the CCMS night staff, SNs and an SEN in rehabilitation settings and CPNs who saw patients in offices. Interviewees in rehabilitation settings felt that they were regarded as 'bouncers' since security staff employed to remove intruders were slow to arrive and often not effective once at the premises. Senior nurses offered diverse views about security staff. The ADNS regarded them as not as effective as the group of male nursing staff who earlier used to do the security work. The night-duty NO regarded the present situation as safer. The night-duty SNO observed that night-duty nursing staff still had to help with security work since only one security officer was on duty at night.

10.1.5 Category 5: Being supported by actions of others

This category focused on nurses' being supported by actions of others over violence and had five properties: willing and able to give support; willing but unable to support; not willing to provide support but feeling that had to; not willing and not providing support; and not recognising that support was needed.

i) Property 1: Willing and able to give support

a) Nurses in the setting. Interviewees on the LW and on the CCMS day shifts, and the rehabilitation hostel night-duty interviewee, described colleagues as supportive. This support was demonstrated through providing immediate assistance when near to colleagues dealing with incidents, through moving to the scene of incidents without request (also contributes to Category 2 *Knowing what to do,* Property 3, Section 10.1.3 iii)) and through supporting each other when managing incidents jointly. In community settings, support was manifest through CPNs' willingness to accompany colleagues

concerned about safety when visiting certain patients and through assisting colleagues faced with difficult situations in offices. Incidents were most frequent on the LW and support from colleagues lessened fear and contributed to wanting to stay on the ward. LW interviewees also described positive support after incidents through visiting colleagues at home who had been injured.

b) Nurses in other settings. Nurses from other settings came quickly to assist with emergencies, and support provided on arrival was regarded positively. Support was also manifest through willingness to accept transfer of patients after incidents.

c) Nurse managers. Nurse managers were not usually present when incidents were being managed; their support was manifest through sending other staff to assist and being supportive of staff involved. No criticism was offered of the speed with which they sent extra staff when requested to the LW and to rehabilitation settings and there was little criticism in the case of the CCMS ward. The CCLS night-duty interviewee said that when he asked for assistance the manager usually came himself. Support from managers for those who had been involved was described as forthcoming by some of the CCMS interviewees. The community nurse manager was described as supportive of visiting in pairs whenever this was deemed advisable. She was the only manager reported to be offering post-incident support through clinical supervision and individual debriefing sessions.

d) Medical staff. Medical staff were not usually present when incidents occurred in institutional settings. Their support was described as coming to the setting when requested to review medication or transfer patients to a different setting. Positive support was forthcoming from psychiatrists in community settings. They accompanied CPNs to emergency calls on grounds of safety, as well as being available to issue a section immediately if appropriate. They stopped CPNs seeing patients who they felt were becoming a danger to the CPNs' safety and, following a particular incident, they supported the case for alarms in nurses' offices.

ii) Property 2: Willing but unable to provide support

Agency nurses on the locked ward were not always able to be supportive in managing incidents through lack of familiarity with ward practices and knowledge of patients

(also contributes to Category 2 *Knowing what to do*, Property 3, Section 10.1.2 iii)). This led to some interviewees becoming fearful about increasing use of agency staff. Rehabilitation interviewees reported that nurses in other settings were willing to assist them but that their arrival was sometimes delayed due to their own commitments and distance from the hostel, and medical staff often took time to reach the hostel, although this was not necessarily their fault (also contributes to Category 4, *Feeling valued*, Property 2 ii)).

iii) Property 3: Not willing to provide support but feeling that had to

LW interviewees said that they occasionally accepted the transfer of a patient to the ward although they felt the transfer was not justified (also contributes to Category 7 '*No win' situations*, Property 3, Section 10.1.7 iii)).

iv) Property 4: Not willing to provide, and not providing, support

a) Nurses in setting. Some male interviewees (the SN on the CCMS night shift and the CNs in the two rehabilitation settings) felt that they lacked support from women. They said that women expected them to deal with all incidents, whether male or female patients were involved, and had to call for assistance from men in other settings when they were the only man on duty. The female interviewees acknowledged that they did not restrain but, nonetheless, emphasised that they were supportive in other ways during incidents.

b) Nurses in other settings. The rehabilitation night-duty interviewee felt that there was a growing reluctance to assist with incidents in other settings as staff were becoming concerned whether those requesting assistance would pull their weight and whether nurse managers would be supportive if patients made allegations that staff had hurt them during restraint. For LW interviewees, lack of support from other staff was manifest by lack of willingness to care for their own patients when LW staff felt they should have been able to do so.

c) Nurse managers. CCMS interviewees reported that their nurse manager sometimes delayed responding to their requests for more staff to manage incidents and on one occasion refused. LW interviewees complained that managers did not visit injured staff, were more concerned with staffing implications than staff welfare, and did not support

nurses against whom patients had made allegations nor nurses who refused to concur with medical staff requests to admit certain patients. In similar vein, rehabilitation interviewees said that managers did not encourage nurses who had been assaulted to charge patients. This rather negative picture was attributed by the locked ward CN to good managers leaving as the hospital was run down towards closure and existing managers being unsupported by managers senior to themselves. The DNS, recently appointed, emphasised that staff who had no alternative but to defend themselves should be supported and gave a recent example of such an occurrence.

d) Medical staff. CCMS and rehabilitation interviewees found that medical staff did not always agree with their recommendations over changing patients' medication or transferring them to another setting as the best means of preventing violence. Consequently, nurses had to continue caring for patients whose level of aggression remained unchanged and was too great for them to contend with. GPs were occasionally unsupportive of CPNs in discharging patients they regarded as too aggressive for CPN care, a response attributed to their now having to visit such patients themselves.

iv) Property 5: Not recognising that support was needed

One LW interviewee felt that after even minor incidents there should be greater awareness that staff involved might need a short break to recover, either away from the ward or somewhere quiet to sit.

10.1.6 Category 6: Judging responses

This category comprised actions constructed in light of perceptions as to how others would perceive and respond to them, and had four properties: patients' perceptions of nurses expectations and intentions; patients' perceptions of nurses' actions over staffing levels; nurses' perceptions of patients' responsibility for actions; and nurses' perceptions of how other health professionals might interpret their actions. This category was influenced by the theory of symbolic interactionism. As discussed in Section 4.3.3 this theory appeared relevant from the outset of the study to understanding interactions between nurses and patients in relation to violence. During the analysis instances also emerged of the ways in which nurses constructed their actions in light of anticipated responses of other health professionals.

i) Property 1: Patients' perceptions of nurses' expectations and intentions

Instances were identified of patients' perceptions of nurses' expectations or intentions decreasing or increasing the likelihood of violence. In all settings, interviewees described a range of interpersonal approaches to patients likely to elicit a non-aggressive response. Examples included: if nurses' behaviour signalled to patients that they could trust them, patients knew staff would not hurt them and were less likely to respond with aggression (CCMS); friendly approaches quickly calming down patients admitted on a section 136 who were very angry on arrival (LW); indicating possible adverse outcomes to patients if they did not comply with a request (rehabilitation hostel, community); and judging when best not to pursue certain topics or activities (LW, day hospital and community). Community interviewees described examples of body language likely to decrease aggression.

CCMS, rehabilitation and community interviewees said that knowledge of violence in a patient's history might influence nurses' approaches to them in a manner that indicated violence was expected (also contributes to Category 2 *Knowing what to do*, Property 4a), Section 10.1.2 iv)). Patients might sense this expectation and respond in kind. Likewise, LW and rehabilitation hostel interviewees reported that patients could sense when staff felt scared which, in turn, might make them fear aggression from staff and respond first with aggression themselves. When patients witnessed nurses summoning help they might perceive that nurses were scared and, fearful of the consequences, respond with more aggression. This perception underpinned requests for alarm buttons in community settings so that help could be summoned unobtrusively. Diverse views emerged in all settings about the role of gender and ethnic group in patients' responses to nurses.

ii) Property 2: Patients' perceptions of nurses' actions over staffing levels

Interviewees on the locked ward and in both rehabilitation settings said that patients could perceive when staff felt vulnerable over short-staffing and that some took advantage of this situation by acting aggressively. When patients were 'ganging up' against locked ward staff they would 'back down' if staff were summoned from other wards. In the day hospital, however, nurses described enlisting patients' help when staffing was low.

iii) Property 3: Nurses' perceptions of patients' intentions

When CPNs thought that patients participating in therapeutic programmes were becoming aggressive towards them, they reminded them of their written agreement not to do so. Knowledge and careful observation of patients in institutional settings facilitated the likelihood that nurses could anticipate imminent violence and respond in a way that lessened the likelihood of escalation. Insufficient staff on the CCLS ward sometimes made anticipation difficult to achieve as did lack of knowledge of intruders' histories in the rehabilitation settings.

Locked ward and continuing care interviewees distinguished between patients whose aggression they perceived as caused by mental illness and those whom they felt knew what they were doing i.e. they were perceived as behaving antisocially. Interviewees accepted the former as part of their job on the grounds that patients were unwell and could not be held responsible for their actions. Regarding the latter, however, interviewees described feeling angry on grounds that such violence to nurses was unacceptable and while they did not respond in kind when feeling angry, subsequent responses included remonstrating firmly with patients and withholding favours.

iv) Property 4: Nurses' perceptions of other health professionals' interpretations of their actions

Most instances in this property focused on managing incidents in a way that took account of how others would judge one's actions. Nurses in charge sometimes intervened in a developing incident more quickly than they necessarily felt was indicated, since they feared that not to do so might be seen as a sign of weakness by others present. Incident accounts were constructed to ensure that managers would not blame those who had been involved. This is in keeping with the observation by Hammersley and Atkinson (1983, p. 141) that such records should be regarded as a demonstration of professional competence, not literal accounts of what happened, and 'constitute a major means of self-defence for the 'face-workers''.

Certain actions were avoided because of the judgement that they might incur complaints: allowing sexual activity between patients (complaints from relatives) and staff taking sick leave after an incident (manager would hold it against one

subsequently). Admitting certain feelings was avoided: men not admitting to other men that they had been scared (fear of appearing weak) and phoning in sick rather than admitting that felt too stressed to work (fear of being regarded as unable to cope). On the other hand certain actions were undertaken knowing that others might disagree but judging that these were in the patients' best interests: allowing patients to hit one as a means of releasing aggression (rehabilitation hostel) and visiting patients alone when knowing that violence was a possibility (community).

Interviewees described judging the moment to move to restraint in light of perceptions of the patients' behaviour but instances were also described of how this judgement sometimes depended on perceptions of how other staff might view the decision. Thus the rehabilitation hostel NA described his involvement as depending on who else was present. When all other staff were women he restrained without being asked whereas, when the male CN was on duty, the NA informed the CN what was happening and became involved only when requested to do so. The night-duty SEN in this setting noted an increasing reluctance to assist with restraint in other settings due to perceptions that if patients were injured, staff involved might be accused of assault (also contributes to Category 5 *Being supported,* Property 4b), Section 10.1.5 iv)). The three senior nurses all said that staff were very anxious about being accused of assaulting patients and both the DNS and the ADNS thought that this fear lay behind the decision to transfer patients to the locked ward as quickly as possible so that they became someone else's responsibility.

There were three instances of judging restraint on the locked ward. Restraint was usually undertaken according to guidelines during the day since other health professionals such as medical staff were likely to be present, whereas this was not the case at night. The opposition of interviewees to student placements was attributed to concern, based on experience, that if students complained about staff actions during restraint, nurse managers would believe students' views of events rather than those of staff. Lack of clarity over the legal position of nurses involved in restraints in which patients were injured would eventually lead to hesitation over restraining.

10.1.7 Category 7: 'No win' situations

Findings revealed several situations which presented nurses with problems whatever option was chosen for their resolution. These were called 'no win' situations. This category had four properties: staff safety versus patients' rights or needs; meeting staff safety versus possibly causing patient aggression; accepting an action that might lead to aggression versus not taking action to prevent it which itself might lead to being blamed for subsequent aggression or other adverse outcomes; and safety of one member of staff versus the safety of another. The phrase 'no win' came from colloquial usage.

i) Property 1: Staff safety versus patients' rights or needs

Informally detained patients had the right to refuse medication but this could present nurses with a dilemma. On occasion they felt that medication would reduce aggression but, if they failed to persuade patients of this, their aggression had to be managed, with concomitant risks to the safety of others. CCMS interviewees added that if they did persuade patients to take medication, relatives sometimes complained that compliance had been forced. Some female CPNs had concerns about their safety when visiting patients in certain areas after dark. If they did not go, however, patients would not receive their evening injection. The solution to this dilemma was to wait until a male CPN was free to make the visit or for another female CPN to be free so that two could do so. Both events, however, sometimes led to delays and patients receiving injections later than desirable.

ii) Property 2: Meeting staff safety versus possibly causing patient aggression

Two actions taken for staff safety were described when the action itself had the potential to provoke aggression. Firstly having information about violence in patients' histories enabled staff to provide care in ways that ensured safety of themselves and others. Having such knowledge, however, could lead to approaching patients in a manner that signalled violence was anticipated, thus increasing the likelihood of a violent response (also contributes to Category 2 *Knowing what to do*, Property 4a), Section 10.1.2 iv) and Category 6 *Judging responses*, Property 1, Section 10.1.6 i)). Secondly, the policy of CPNs visiting in pairs for safety when travelling to certain housing estates, or when aggression was anticipated from patients, was undertaken knowing that the presence of two staff could provoke aggression.

iii) Property 3: Either action taken could lead to adverse outcomes

Situations were described in which staff felt that they had to take actions with patients knowing that this might cause aggression, yet also knowing that not to do so might lead to aggression or other adverse outcomes for which they might be blamed. An instance from the locked ward was that of staff being asked to accept patients from other wards when they thought not only that this was unnecessary but also that it might contribute to disturbances on the locked ward. If locked ward staff refused such requests, however, and incidents then occurred on the patients' own wards, they might be blamed for not having acceded to the initial request. Another instance from the locked ward concerned lack of food. If night staff refused patients bread when hungry at night, patients became angry with staff. Yet if night staff agreed, day staff were angry with them because there was insufficient bread for breakfast.

CCMS interviewees were presented with dilemmas about the safety of informally detained patients who had the right to leave the ward whenever they wanted. In the evenings staff were anxious for patients' safety when off the ward and feared being blamed if mishap befell them, but patients could become angry if staff tried to dissuade them from leaving. On the CCLS ward, patients could become angry when asked to vacate a wet bed so that it could be changed yet, if staff did not to do this, they could be blamed for failing in their duty of care to patients. The 'no win' incident described in the rehabilitation hostel was the CN asking an ex-patient to leave, knowing this might cause aggression. If no such action had been taken, the ex-patient might have caused an incident for which the CN would be blamed.

iv) Property 4: Safety for staff ensured through one action possibly causing other dangers to same or other staff

The instance in this property was community based. CPNs sometimes discharged a patient from a one-to-one relationship when the CPN and/or their line manager or medical staff thought that the patient might pose a threat to the CPN's safety. The CPNs feared, however, that not only might patients be sufficiently angered by the discharge to seek retribution against the CPN but also they might attack others to whose care they had been assigned.

10.2 DEVELOPING STRATEGIES ACROSS THE SERVICES

The presentation of the seven categories has demonstrated the ways in which many of the properties of which they were comprised focused on strategies concerned with the prevention and management of violence. Interviewees perceived that some of these strategies lay within their power to implement, whether or not staff did actually implement them. The power to implement other strategies, however. lay with different personnel or organisations. These personnel and organisations reflected the way in which nursing staff were at the centre of a spatial framework of geographical and health service boundaries and were at the base of a hierarchy of nursing personnel above which was a hierarchy of mangers at district level and beyond who made decisions about service provision and resources. Nurses in institutional and community settings also related to hierarchies of medical staff who made decisions about the admission and treatment of patients. For each of the personnel and organisations regarded as responsible for implementing strategies, this section draws the findings together across the settings.

10.2.1 Nurses in charge

Strategies identified for nurses in charge were grouped into: individual expertise; relationships with people *within* the setting; and relationships with people *outside* the setting.

i) Strategies focusing on individual expertise

These strategies included creating a ward atmosphere that lessened the tension that could contribute to incidents, deploying staff effectively and being able to take the lead over decisions about actions needed when incidents were developing.

ii) Strategies focusing on relationships with others in the setting

These strategies included supporting learners in gaining confidence in handling incidents. teaching nursing auxiliaries about violence. being willing to listen to ideas of junior staff and nursing auxiliaries, ensuring that staff have available information about patients' histories. and initiating meetings to discuss specific incidents and the subject of violence generally. Positive and negative instances were advanced for each.

iii) Strategies focusing on relationships with people outside the setting

These strategies included being assertive with medical staff and multidisciplinary teams over suitability of patients for admission to the setting and ensuring that patients' relatives are fully informed about treatment plans. There were examples of a lack of willingness to share expertise across settings: not developing consistent care polices; and not discussing different approaches to management of incidents.

10.2.2 Nurses in the setting

As with nurses in charge, strategies identified for nurses in the setting were grouped into: individual expertise; relationships with people *within* the setting; and relationships with people *outside* the setting.

i) Strategies focusing on individual expertise

These strategies included: appropriate approaches to patients; awareness of possible outcomes of different approaches (speech and body language); providing patients with information; careful observation; ensuring that they had sufficient information about patients to inform appropriate approaches; having skills in de-escalation of incidents; knowing how to restrain safely; having confidence to rely on own judgement rather than acting according to expectations of others; and being willing to initiate discussions. While interviewees provided mainly positive examples of these strategies, references were made to instances when they or others had not employed them.

ii) Strategies focusing on relationships with others in the setting

Strategies for which only positive instances were cited included: passing information onto colleagues; supporting learners in learning about preventing and managing violence; and accompanying colleagues on community visits. Strategies for which positive and negative instances were described included teaching nursing auxiliaries about violence, formulating care plans in discussions with colleagues and willingness to discuss violence generally and specific incidents. The only negative instance cited in relation to supporting each other in the management of incidents was that of male interviewees who felt unsupported by women, although the women dissented from this view. Possible strategies that were not implemented included discussion of sexual frustration as a possible cause of violence, discussing guidelines with colleagues and

showing awareness that staff involved in incidents might need space and time to recover.

iii) Strategies focusing on relationships with people outside the setting

Positive instances only were cited of concern about transferring patients to the care of other staff when deemed too dangerous for the CPN currently responsible. In the main staff were described as being willing to assist with emergencies on other wards. There were both positive and negative instances of willingness to manage own patients whenever possible and not request transfer to other settings. Accounts of incidents were constructed carefully before making them available to others.

10.2.3 Medical staff

Strategies identified for medical staff were grouped into: individual expertise; relationships with people *within* the setting; and relationships with people *outside* the setting.

i) Strategies focusing on own expertise

Only one strategy focused on individual expertise. This was the need for medical staff to develop better procedures for assessing patients so that those with personality disorders could be diagnosed as such and referred elsewhere.

ii) Strategies focusing on relationships with people in the setting

Strategies for which medical staff were regarded as responsible but who did not always implement them included: discussing patients' treatment with them at the outset of their programme of care and being available subsequently to discuss it; and providing nursing staff with information about patients that was important in informing nurses' subsequent approach to patients. GPs in particular were criticised for not providing CPNs and patients with adequate information and placing CPNs at risk.

Views differed among interviewees in the three institutionally based services as to whether medical staff did, or should, take account of nurses' views about the appropriateness of patients for admission and the nature of their subsequent treatment. The key point about failure to take account of nurses' views was that the outcome was, or was regarded as likely to be, increased violence encountered by nursing staff.

Medical staff were always described as being willing to accompany CPNs on emergency visits and as coming to wards when requested; delays in the latter were occasioned by other commitments rather than reluctance.

iii) Strategies focusing on relationships with people outside the setting

Two strategies were viewed critically: lack of liaison or arguments with other consultants about transferring patients from one setting to another, sometimes resulting in an inappropriate mix of patients for nurses to care for; and asking nurse managers to overturn decisions to refuse admission made by the nurse in charge of the locked ward.

10.2.4 Managers

Strategies identified for managers were relationships with setting staff, providing post-basic opportunities, policy development and providing resources. In some cases it was clear to whom interviewees were referring, be it their immediate line manager, senior nurse managers at the site, or more senior managers (nurses or otherwise) at a higher level of responsibility. In other cases it was not clear to which level of manager interviewees were referring and indeed they might not have known themselves.

i) Strategies focusing on relationships with setting staff

In all the institutional settings, nurse managers were criticised for believing patients' rather than nurses' accounts of incidents when these differed. They were also criticised for not encouraging nurses to bring charges when assaulted. Views varied as to whether they supported nurses who had been involved in incidents and were sympathetic to those who had been injured. Sending extra staff when requested and coming themselves to assist was mainly referred to positively. While the community nurse manager was involved in one-to-one and group discussions about violence, in institutional settings views varied as to whether managers were, and should be, involved in such discussions. Nurse managers were criticised for not supporting nurses who had opposed medical staff decisions to admit patients for whom they did not have resources to care.

The strategy of involving staff in policy decisions that affected their working life was not implemented. Instances of actions undertaken without prior discussion with staff included moving patients between continuing care settings, moving the locked ward

facility to a different building, changing the arrangements for admitting patients on a Section 136 and developing guidelines for preventing and managing violence.

ii) Providing post-basic opportunities

Lack of, or very little, provision by managers of post-basic courses on violence was the case in the institutional settings with community staff reporting some availability. A reason cited for this lack was reluctance to confront the subject. Other negatively perceived actions included the following: no opportunities for night staff to attend courses; discontinuation of a forum for night staff to meet and share experiences; discontinuation of a staff rotation scheme that facilitated gaining wide experience; and sending staff on courses that had little relevance to their educational needs. Increasing provision of courses was, however, reported.

iii) Policy development

Inappropriate policies included unrealistic timescales for the management of change, in particular closure of hospital wards and transfer to rehabilitation and community settings and allowing non-residents to use the hostel canteen. Guidelines for patients' sexual activities, clarification of nurses' position in relation to restraint and a policy for staff to have 'burn out' days were lacking.

iv) Providing resources

In relation to security resources, a positive instance was that of providing locks for the day hospital doors to deter intruders. Most instances were negative, however, and mainly revolved around not fitting alarms that would enable nurses to summon help quickly and unobtrusively. Views varied in institutional settings as to whether managers were providing enough staff. In the main, however, staffing was seen as inadequate for implementing the programme of care. This was nearly always in relation to having sufficient staff who were experienced to restrain safely, and in the community to having a policy of visiting in pairs when risks were apparent. The mix of staff was also seen as a problem; in the locked ward making up numbers with agency staff and in the rehabilitation settings having too high a proportion of recently qualified staff. Lack of resources in the form of equipment, materials, places in therapy departments, food and cigarettes were each identified in one or more of the institutional settings and lack of adequate space in the locked ward.

10.2.5 Tutorial staff

Strategies for which tutorial staff were regarded as responsible included preparation of learners and relationships with service staff.

i) Strategies focusing on preparation of learners

These focused on ensuring that learners were adequately prepared in relation to preventing and managing violence. Interviewees were mainly critical of tutors who had been responsible for their own preparation and, with the exception of community interviewees, critical of tutors at the site currently preparing learners. A second area of criticism of tutors focused on their opposition to placements on the locked ward.

ii) Strategies focusing on relationships with service staff

Relationships with service staff focused on discussing learners' concerns about incidents that they had witnessed, or been involved in, with managers rather than discussing these initially with staff in the setting. Lack of contact between tutorial and service staff was criticised with reference made to a previous forum that existed for discussion of the programme by both groups. The DNS and ADNS stressed the importance of tutorial and service staff working together more closely.

10.2.6 Multidisciplinary team

Multidisciplinary teams mainly supported but occasionally overrode nurses' views about the appropriateness of certain patients for admission to the residential hostel. They provided good quality discussions about violence by the team at the community mental health centre, including support for measures to improve nurses' safety.

10.2.7 National organisations

Three strategies emerged that were the responsibility of organisations with a national remit, although not always specifically identified as such by interviewees.

i) Legal position of the nurse

Reference was made to those responsible for the 1983 Mental Health Act since it was regarded as inadequate in protecting nurses who felt that they had acted in good faith in the course of incidents that resulted in allegations of assault. The Act was also regarded

as failing to clarify nurses' position over medication. searching for weapons and use of restraint in the case of informally detained patients.

ii) Provision of mental health services

There was criticism of those responsible for the provision of mental health services. The selective nature of secure unit policies made it very difficult to arrange transfer of patients regarded as needing the level of security these units provided, and there was perceived lack of facilities in the community for those ready for transfer to this setting.

iii) Educational provision

The current curriculum for learner nurse training was regarded by one manager as an improvement on its predecessor because of its increased emphasis on interpersonal relationships; she regarded these as important in preventing incidents.

10.2.8 OVERVIEW OF PERCEPTIONS OF STRATEGY IMPLEMENTATION

Nurses in the six settings usually implemented the strategies that they identified as lying within their sphere of responsibility, although there was recognition that advocated strategies were not always implemented. Views about medical staff implementing desired strategies included positive and negative instances. Nurse managers and other managers were perceived in a fairly negative light. One of the charge nurses offered the view that lack of support from nurse managers for the setting staff was due to the managers' own lack of support, good managers having left in the face of uncertainty over closure and the closure programme creating loss of morale for remaining managers. Tutorial staff were perceived in an almost entirely negative light, highlighting the divide between education and service prevalent at the time. There was criticism of policies operating at national level in relation to the 1983 Mental Health Act and to the provision of appropriate facilities for patients.

10.3 A FRAMEWORK FOR CONSIDERING IMPLICATIONS OF FINDINGS

Having reached this point in the analysis of the data I considered what implications it might have for policy development in relation to violence and found helpful an approach advocated by Vincent *et al.* (2000) for analysing all serious incidents in mental health settings. not only violence. Vincent *et al.* (2000) were concerned that

inquiries into adverse events tended to concentrate on individuals involved and apportion blame accordingly rather than consider how failings in the system as a whole might have contributed to the event. Drawing on an organisational accident model developed by Reason (1990, 1995, 1997) for analysing industrial accidents. Vincent *et al.* (2000) developed a framework for analysing adverse events which aimed to understand the influence on the event of factors located outside the setting as well as those within. Such an analysis might reveal unsafe aspects of the organisation, such as deficiencies in training and problems over communication, and they maintained that 'interventions need to be made at these higher levels if the overall safety of a unit is to be increased' (Vincent *et al.* 2000, p.91).

A broad framework of factors at different levels in an organisation, together with factors in the national institutional context in which the organisation is located, was developed and used for the analysis of specific incidents (Vincent *et al.* 2000). The framework comprised patient characteristics, task factors, individual staff factors, the work environment, organisational and management factors, and the institutional context. This framework seemed to offer a 'fit' with the people and organisations that interviewees in my study had identified when discussing strategy implementation in relation to preventing and managing violence. The first level of the framework to which interviewees in my study referred was that of individual staff members. Factors identified by Vincent *et al.* (2000) at this level included knowledge, skills, competence and motivation and interviewees in my study described their perceptions of themselves and others in the setting in respect of these.

The next level in Vincent *et al.'s* framework was that of the team. When Vincent *et al.* developed their framework, multi-professional teams were very much the norm in mental health services. At the time of my study, however, this was not the case; the development of multi-professional teams was at an early stage. From the perspective of interviewees, the 'team' was described in terms of the nursing staff; medical staff and line managers being related to the team rather than part of it. (The community service line manager, however, was an exception.) Some of the various factors that Vincent *et al.* categorised as team factors (verbal and written communication between staff, supervision and seeking help, congruence and consistency of aims, and leadership)

were, however. included in interviewees' perceptions of the responsibilities of setting staff, medical staff and line managers.

The next two levels in Vincent *et al.'s* framework, organisational and management factors and the work environment, corresponded with those perceptions of my interviewees that I had grouped under the generic heading of 'managers' and tutorial staff. In Vincent *et al.'s* framework, organisational and management factors included financial resources and constraints, policy standards and goals. educational and training policy and safety culture and priorities. Work environment factors included staffing levels and skill-mix, workload, environment, equipment and supplies, and building and design. Strategies which interviewees in my study considered managers to be responsible for included: relationships with setting staff; providing post-basic opportunities; policies for service development and patient and staff welfare; and providing resources (security features, staffing, equipment, materials, adequate space). Responsibility for the education of learners lay with tutorial staff with input from service staff.

The institutional context in Vincent *et al.'s* framework included factors at a national level such as government policy, the macro-economic climate and regulation of professions. In my study, interviewees' perceptions of factors at this level included government policies concerning adequate provision of facilities for the care of patients and aspects of the 1983 Mental Health Act.

This framework informed consideration of the policy implications of this study (Section 11.5).

10.4 REFLECTING ON THE ORIENTATION OF MY WORK

Before moving to the final chapter of discussion and conclusions. I include a reflection on my orientation to this study. As observed in Section 1.1. I work in a Department of Health funded unit that undertakes research to inform policy development in relation to the nursing and midwifery workforce. The work in the unit for which I have been responsible has concentrated on professional roles and interrelationships. aspects of pre-registration and post-registration education, career development and conditions of

working life. The project from which this thesis was developed was commissioned in response to what was perceived as a problematic area for the nursing profession. Undertaking the work for a postgraduate degree, however. provided me with the opportunity to read and reflect in greater depth than for commissioned work. This included considering different epistemological positions and their relationship to methods (Sections 4.1 and 4.2) and included drawing on sociological perspectives in some respects in the development of categories (Section 4.3.3 and 10.1.6).

The conceptual framework (Section 4.3.2) was primarily developed, however, from a reading of policy and research literature focused on violence as it related to the education and role of professional practitioners and this is reflected. to a large extent, in the nature of the categories that emerged from data analysis. All projects of this kind involve choices about which approaches and relevant conceptual schemas they, on the one hand, merely touch upon and, on the other, make central to their argument. With hindsight, I accept that I might have made different choices about which aspects of the literature to make central to the development of my conceptual schema. It may also be the case that my reading of the policy literature may have been too closely attached to that concerned with the mental health services and with the nursing workforce, a limitation that could be remedied in further publication.

CHAPTER 11: DISCUSSION AND CONCLUSION

This final chapter provides a discussion of the methods adopted and the findings that emerged. Section 11.1 provides a critical assessment of the strengths and limitations of the research design and methods. Discussion of the contribution of the study follows in Sections 11.2 and 11.3 and the generalisability of the findings in Section 11. 4. The chapter concludes with consideration of the implications of the findings for policy (Section 11.5) and further research (Section 11.6).

11.1 STRENGTHS AND LIMITATIONS OF THE DESIGN AND METHODS

Strengths and limitations of the study are considered in the context of: gaining access to views on a sensitive subject (11.1.1); selection of site, settings and interviewees (11.1.2); methods of data collection and analysis (11.1.3); contribution to knowledge (11.1.4); and length of time between data collection and final reporting (11.1.5).

11.1.1 Gaining access to views on a sensitive topic

Gaining access to views on a sensitive subject had two aspects, obtaining the agreement of a professional group to participate in the project and obtaining valid data from individual members of the group. I was successful in gaining access to the selected site, services and settings and obtaining agreement for interviews from the majority of those approached. This was achieved through careful preparation and presentation of self (Sections 5.2.1.ii) and 5.3.3 iii)). A limitation was failing to obtain agreement of all those approached and, on reflection, I should have been more persistent with those who declined to participate and those who agreed to do so but who repeatedly cancelled arrangements. I gave consideration to whether those who did not participate differed in any way from those who did. The non-participants did not appear to differ in terms of representing a particular grade, age or ethnic group, but I was unsure whether their views about violence might have done so.

Overall I felt that I had obtained valid data from interviewees, as indicated by their willingness to talk in depth and at length about violence and my sense that I was not being fobbed off (Section 5.5.5 vii)). The overall success was due to my spending

sufficient time in the site to gain an understanding of the frameworks which people brought to the interview (Section 5.3.3), asking about topics that interviewees perceived as relevant and designing interview guides that provided a balance between structure and openness (Section 4.5.2), ensuring, so far as able, that the interview environment was conducive to interviewees feeling relaxed (Section 5.5.4) and being sensitive and attentive to interviewees' responses (Section 5.5.5).

11.1.2 Selection of site, settings and interviewees

Careful selection of site and settings ensured that the phenomenon under consideration, violence, was manifest frequently enough for interviewees to experience it as relevant to their working lives and for their experiences to be likely to resonate with those of nurses working in the same services elsewhere. The decision to include all grades of staff meant that differing perspectives could emerge.

The focus of the research was views and experiences of *nurses* in relation to violence but it was recognised that perspectives on violence held by patients and other health professionals, particularly medical staff, might well have implications for the role of nurses in relation to this aspect of patient care. Consideration was given to whether these groups should be included but a decision reached not to do so (Section 4.4) on grounds of time, recognition of difficulties that might be encountered in interviewing patients and that obtaining nurses' perspectives was the main objective and should not be compromised.

The last point proved important. Findings showed both that nurses perceived patients as sometimes holding views differing from theirs about specific incidents and that managers were more likely to believe patients than nurses. Findings also showed that nurses perceived medical staff as sometimes holding views differing from theirs about the causes of violence. Had patients and medical staff been included, nursing personnel might have seen the research as being about conflicting perspectives rather than focusing on nursing concerns, so might have been less willing to participate and to do so without inhibition. In this sense, the decision to focus only on nurses was a strength of the study. The lack, however, of patient and medical staff perspectives which might have illuminated the problem for nursing, is a limitation. Such perspectives are still regarded as lacking (Benson and Balfe 2001).

11.1.3 Methods of data collection and analysis

i) Data collection

Data collection was guided by a conceptual framework developed primarily from a review of policy (Chapter 2) and research (Chapter 3) literature. The interview guide was developed from the dimensions of the conceptual framework and appeared to have been a successful balance between on the one hand, relevance and completeness and on the other, sufficient openness. The former was indicated in that, when asked, most interviewees said that the interview had given them the opportunity to discuss all aspects of violence. The latter was indicated by several new aspects of certain topics being raised and then included in subsequent interviews, for example sexual frustration as a source of violence.

My intention had been to cover all topics with all interviewees in order to ascertain commonality and divergence of views and experiences across the various dimensions of the conceptual framework. Although most interviews were complete, or nearly complete, there were some in which whole topics, or aspects of topics, were not discussed. Some interviewees became very discursive on particular points and I failed to redirect the discussion to cover outstanding topics before the interview had to be curtailed. Topics concerned with the interviewee's education in relation to violence came toward the end of the guide and were the most likely to be incompletely covered. The number of interviewees discussing each dimension varied, as did the number who expressed views on themes within the dimension. In order to make this clear in the text, I indicated the number of interviewees who discussed each dimension and the number making each observation.

Another limitation of the study was that interviewing each person on one occasion only did not provide the opportunity to explore differing perceptions of the same topic. For example, on some shifts, interviewees differed over whether post-incident discussions were held. Further exploration might have revealed whether this was because they had different ideas of what constituted a post-incident discussion. Likewise, differing perceptions between some male and female interviewees of whether the latter were supportive in managing incidents could usefully have been explored.

ii) Data analysis

For reasons described in Section 4.6, I decided against using a computer software package to assist the process of data analysis. Since that time, there has been a large increase in the number and sophistication of packages available, accompanied by debates about their advantages and disadvantages (e.g. Mason 1996, Morison and Moir 1998, Pateman 1998, Webb 1999). These debates focus on the processes of coding and retrieving segments of data and of interpretation and theory building. In relation to the former, there is agreement that these programs greatly facilitate and speed up the process. As the above authors observe, however, there have been debates over whether programs enable adequate familiarity with transcripts, lead to systematisation of codes at too early a stage and lead researchers to focus on program technicalities rather than data analysis. With regard to interpretation, debates have focused on whether the structure of the selected program supports a specific analytical and explanatory strategy that may not be consistent with the researcher's evolving approach (Mason 1996, Moir and Morison 1998). In reflecting on the strengths and limitations of the procedures I adopted, consideration is also given to the role that a computer program might have played.

The approach to undertaking preliminary data analysis concurrently with data collection was described in Section 5.6. This included reflecting on interviews after completion, transcribing as many tapes as possible and applying the coding legend developed from the conceptual framework to a proportion of these. This process resulted in early analytic ideas that formed the basis of a preliminary paper to guide initial stages of the post-fieldwork analysis. However, I did not keep transcription fully up to pace for this analysis to be as intensive as desirable.

The strength of the approach to post-fieldwork data analysis was in achieving a balance between being creative and being systematic (Section 5.8). The initial phase of the analysis involved a considerable amount of manual 'cut and paste' procedures and a computer program would, I feel, have facilitated these. The system I used, however, ensured great familiarity with the material. The process of grouping cards together by each dimension of the conceptual framework, spreading them out for reading as a whole, and then re-grouping, enabled me to refine the key themes within each dimension and to identify the range of interviewees' views and experiences. I am

unsure whether this flexibility would have been enhanced or hindered by the use of a computer program.

The emergence of the categories had a similarly developmental nature and a balance between being creative and being systematic. Early analytic insights that emerged during fieldwork were developed further during the initial (5.8.2) and revised (5.8.3) phases of analysis. The categories were continually refined with new ones emerging and existing ones disappearing or being merged into others. Once a final set of categories had been developed, these were systematically re-applied to ensure that these 'fitted' the data and that links between indicators in the data and the categories and their properties had not been lost. The developmental nature of the analysis facilitated the clarification of the research problem (Section 5.8.5). The question of whether a computerised system would have helped me in gaining further analytic insights cannot be answered with certainty.

11.1.4 Contribution to knowledge

In discussing the strengths and limitations of the study in terms of its contribution to knowledge, consideration is given to two questions: what do qualitative interview data represent; and what is meant by contribution to knowledge. In Section 4.5.1, I observed that views expressed by Silverman (1985) on how data obtained through qualitative interviewing should be regarded were those that I adopted for this study. Silverman (1994) has reiterated these views and more recent expositions have been provided by, for example, Miller and Glassner (1997). While qualitative interviewing enables researchers to gain an understanding of the views and experiences of research subjects, 'these narratives come out of worlds that exist outside of the interview itself' and thus also provide a means of learning about this social world (Miller and Glassner 1997, p. 105). The interviews undertaken for this study explored nurses' perceptions and experiences in a range of settings, but were also regarded as a means of learning about the factors that shaped their experiences.

In thinking through what contribution to knowledge is made by this study, I returned to Hammersley and Atkinson's series of what they called 'way stations' along the road to theoretical development (Section 4.1.4). They argued that researchers can make useful additions to knowledge at each of these 'way stations' (Hammersley and Atkinson

1983). The first 'way station'. descriptive accounts of unknown ways of life. is represented in this study by the views and experiences of staff working in settings who had not previously been studied in this degree of depth nor on such a wide range of topics (Chapters 6 to 9). The generation and presentation of such material, however. involves selective interpretation and conceptualisation (Jones 1985b. Silverman 1985) and in this study this was achieved through developing and revising a conceptual framework of dimensions of violence.

The second 'way station' has three levels of attempting to develop theoretical models. The first is the collection of features of the phenomenon under more general categories and this level of development is represented in this study in two ways. First, the seven substantive categories (Section 10.1) were developed from the detail of findings for each of the dimensions of the conceptual framework. These categories were entitled: appropriate placement of patients; knowing what to do; willingness to discuss; feeling valued; being supported; judging responses; and 'no win' situations. Second, these categories were linked by a set of patterns within the data concerned with strategies to prevent, reduce and manage violence with a distinction emerging between those that nurses perceived as lying within their power to implement and those that lay without (Section 10.2).

Hammersley and Atkinson's next level of theoretical model is that of developing typologies of perspectives or strategies. In this study, this level is represented in some of the categories in that their properties demonstrated a continuum of positive through to negative instances of the implementation of strategies. In this respect they revealed a greater complexity in the patterning of actions than had hitherto been demonstrated. The final level of theoretical development is the integration of a range of analytic categories into a model of social processes. This level was not attained in this research although at the design stage I had identified reaching it as a possible goal.

Contributions of this study in terms of accounts of ways of life. categories and typologies are presented in Sections 11.2 and 11.3.

11.1.5 Length of time between data collection and final reporting

For reasons discussed in Section 1.2, a long period of time elapsed between data collection and final reporting. This presented problems in how to present subsequent work in the field (Section 3.10) and required particularly careful consideration of the relevance of the findings to today's mental health services (Section 11.4).

11.2 ACCOUNTS OF LIFE IN SETTINGS

Most research prior to my study had focused on the incidence of violence and whether associations could be identified between these events and patient and/or staff characteristics (Section 3.1). Some of these studies had obtained nurses' views about incidents through questionnaires or semi-structured interviews. Nurses' views on the experience of restraint and on being assaulted had been obtained through interview studies. Through means of a questionnaire survey, one study had focused on a wider range of topics than just the nature and experience of incidents (Brailsford and Stevenson 1973). Most of the studies focused on single settings, usually acute, although others had included a wider range of institutional settings.

There had, as far as I could ascertain, been no previous qualitative work exploring a wide range of aspects of violence from the perspectives of nurses working in the main services for adult patients, including community. Through in-depth interviews with nurses, I was able to explore their perceptions of many aspects of violence: its frequency and explanation; means of preventing and managing incidents; the nature of post-incident events; relationships between and within professional groups involved; their feelings about violence; and their views about their legal position. The study provided a wealth of material on the ways in which nurses perceived a wide range of factors as impacting on the generation of violence and on their role in its prevention and management. By including a range of settings, the study revealed a range of common concerns in the very different situations in which violence may occur (Chapters 6 to 9).

11.3 THE SUBSTANTIVE CATEGORIES

This section focuses on the contribution made by the seven substantive categories and the linking 'strategy implementation' category.

11.3.1 Category 1: Appropriate placement

This category concerned the appropriateness or otherwise of placement of patients and had four properties: appropriate for admission; setting appropriate but patients unable to be referred or retained; placement initially appropriate but not currently (transfer needed within institution or to setting outside); and patients inappropriate for admission from outset (too aggressive, treatment not available, intruders).

i) Prior to study

When this study commenced, placement of patients in settings appropriate to their needs had been a long-standing policy issue. Problems existed in moving patients between ordinary psychiatric hospitals and more secure settings as their need for security either increased or decreased. There was continuing debate about the appropriate placement of patients with personality disorder; the main union of the time maintaining that these patients were inappropriate for placement in ordinary psychiatric hospitals (COHSE 1977). Guidelines on violence focused on ensuring, prior to admitting patients, that nurses had the resources to care for them and research on nurses' experiences and views had shown the importance that they attached to being involved in such discussions. Inadequate provision of community facilities meant that the discharge process for individual patients could be delayed and research suggested that this could contribute to the incidence of violence in rehabilitation settings.

ii) Findings from this study

This study revealed that nurses in all institutional settings perceived the inappropriate placement of patients as contributing to the violence that staff encountered. Interviewees identified a wide range of people and organisations as having responsibility for aspects of ensuring that patients were appropriately placed. Some patients were admitted to the hospital whose level of violence was regarded as requiring resources in excess of those available, including those with personality disorder and those admitted in a drug-induced psychosis. While nurses could be assertive with medical staff over admission of such patients, essentially they saw admission as a matter of decision-making by

others, and perceived these decisions as made in a context of inappropriate policies and inadequate services for patient care. This study also showed how nurses perceived appropriate placement in terms of relationships between, and pressures on, staff in different institutional settings but showed that strategies to resolve these lay outside their sphere of responsibility.

In summary, while it was nurses in the setting who were most likely to encounter violence from inappropriately placed patients, they perceived themselves as having limited influence over patient placement. The decisions of others and the effects of organisational policies had a greater impact than any actions that nurses could take. While there was some recognition of the pressures that medical staff and nurse and service managers were under in relation to placing patients, they were nonetheless criticised for failing to take nurses' views into account. Policies of organisations from local to national level were identified as impacting on nurses in relation to admission criteria, the adequate provision of facilities and timescales for the implementation of new policies.

iii) Subsequent developments

The review of developments since this study was undertaken (Section 2.7) demonstrates that an understanding of nurses' perceptions of the appropriate placement of patients is as relevant to today's mental health services as it was to those at the time of this study. There is much concern about the appropriateness of admissions to acute units in terms of perceived risks of violence. There is also concern about lack of provision of secure beds and continually nursed beds; this results in overcrowding in acute units, which is itself regarded as conducive to violence. Debate continues about the appropriate placement of patients diagnosed with personality disorder (Section 2.11). Provision of facilities and services for care in community settings has increased greatly since the time when the study was undertaken but there is concern that changing policies have meant that a group of patients are now community-based who may pose a risk to the safety of nurses and others (Section 2.8).

11.3.2 Category 2: Knowing what to do

The 'knowing what to do' category was concerned with nurses' perceptions of sources of guidance in preventing and managing violence and had four properties: experience

and observation: theoretical teaching: working as a team: and written documentation (patients' histories, guidelines and the 1983 Mental Health Act). The study revealed a range of factors, in addition to interviewees' own first level and subsequent education, that they perceived as relevant to staff knowing what to do. It also revealed ways in which they perceived these factors as lying within their power or being influenced by the actions of other people and the policies of organisations beyond the setting.

i) Prior to study

As discussed in Section 3.9, none of the UK studies concerned with the education of mental health learners had focused specifically on learning about violence. My own research on the views and experiences of learners has focused on this topic and has revealed considerable discrepancy between teaching and practice (Robinson 1990, 1999). In the period prior to this study, there was recognition of a need for staff to be able to refer to written guidelines to inform their actions; several such documents were produced and there were mixed perceptions of their usefulness (Section 2.2.2).

ii) Findings from this study

This study showed how interviewees perceived discrepancies between school teaching and realities of practice, in relation both to their own education and to that provided for learners at the case-study site. Since interviewees were service staff it is perhaps not surprising that they perceived this discrepancy in terms of tutorial staff having an unrealistic view of the realities of working on the wards.

In several ways, this study added to what was known about educational preparation in relation to violence. Some interviewees maintained that recently qualified nurses were less well prepared than previously, due mainly to lack of experience in acute care settings as learners and as newly qualified staff. This lack restricted the range of patients who could be admitted to the setting and placed greater onus on the nurse in charge to manage all incidents. This study revealed the importance that staff accorded to their own acute care experience and also identified barriers to others gaining this experience. Some ward staff in acute settings did not want learners present and some tutorial staff opposed locked ward placements. Some staff recollected their own reluctance when they were students to have acute care placements, and the ending of a staff nurse rotation scheme was regretted.

With regard to post-basic education this study showed that. with the exception of community staff, it had received very little emphasis at all and examples of courses focusing on violence were few and far between. This resonated with the national picture revealed in surveys covering the 1984 to 1986 period which demonstrated that District Health Authorities had made little provision for courses on violence and that only one post-basic course focused specifically on the subject (Robinson and Barnes 1988, 1989). New insights emerged in that some interviewees felt the lack reflected a reluctance to acknowledge that violence was a problem. With the exception of the community interviewees, no reference was made to the availability or otherwise of clinical supervision.

This category included team working as a factor that nurses perceived as relevant to whether they and others knew how to prevent and manage violence. The study revealed how nurses regarded good working relationships between members of a long-standing team as a source of knowledge about preventing and managing violence. Some shifts developed patient care plans and a collective understanding about when and how to restrain. The study also demonstrated that nurses were concerned about the employment of agency staff on grounds that they lacked knowledge of how best to approach patients or were hesitant to participate in restraint. The study also showed, however, that some interviewees perceived an inertia among qualified staff about developing care plans and discussing ways of managing violence.

This study showed that guidelines featured very little in interviewees' consciousness or experiences of violence although there was recognition that staff could get together to discuss their content and its relevance to their practice. Information provided by other health professionals, mainly in the form of patients' histories, was also identified by this study as an important source of guidance for staff actions. Access to such information did, however, raise the question for interviewees that it might influence their approach to patients in a way that could increase the likelihood of violence. This study also identified ways in which CPNs, in particular, felt that they could be endangered by lack of information provided by general practitioners.

Finally, the Mental Health Acts featured as a source of guidance or otherwise for staff actions. Though primarily referred to in relation to support for nurses accused of assault, the Acts were also mentioned in the context of clarity about nurses' legal position when restraining patients. A perceived lack of clarity led some to express the view that nurses would hesitate once having decided that restraint was the best course of action. Prior to my study, the main union representing psychiatric nurses had expressed the view that the 1959 Mental Health Act did not support staff (COHSE 1977). In contrast, this study showed that nurses looked back on the 1959 Act as having supported nurses, whereas they regarded the 1983 Act as not doing so.

iii) Subsequent developments

Preparing nurses to prevent and manage violence has continued to be a matter of concern at both pre-registration and post-registration level (Section 2.9). As in this study, this concern has focused on lack of experience in acute settings and differing perspectives of teaching and service staff (Section 2.9). There has, however, been an increased emphasis at both levels on the subject of violence and the development of courses concerned with specific techniques (Sections 2.9, 3.16). Nonetheless, concerns remain about the level of resources available to ensure the implementation of continuing professional development (e.g. Sainsbury Centre for Mental Health 2000).

The development of teams, which appeared so important to interviewees in acute settings, may be difficult to achieve in certain parts of the country with the increasing use of agency staff (Gournay *et al.* 1998). Recent guidelines stress the importance of information about violence in patients' histories being available to all health professionals likely to be involved in their care. With regard to guidelines available at local level, however, recent surveys (Noak *et al.* 2002) have highlighted diversity in recommendations and problems in ease of access. The nurses' legal position in relation to violence remains under discussion (Section 2.11).

11.3.3 Category 3: Willingness to discuss

The category 'Willingness to discuss' had two properties: discussion to formulate care plans for patients with a view to preventing violence and discussion of specific incidents.

i) Prior to study

Guidelines published prior to this study espoused the view that all incidents should be discussed and recommended that the purpose of such discussion should be constructive criticism with a view to improving practice rather than apportioning blame. Little research, however, had investigated the frequency of such discussions or staff perceptions of their value. One of the incident studies that I reviewed, however, showed that not all incidents were discussed and embarrassment at having made a mistake was one of the reasons offered for this (Aiken 1984).

ii) Findings from this study

This study did not explore discussion of specific incidents but it did seek interviewees' views on incident discussion generally. Findings showed that restoration of morale and providing suggestions for improving practice were among the benefits identified. Not all discussions were regarded as useful, however, and some were perceived as unhelpful in terms of tone and content. A wider range of reasons was identified than had been hitherto as to why staff might be reluctant to engage in discussion. These included admissions of inertia, the wish of some to maintain a position of control through not sharing expertise, the feeling that to acknowledge the existence of violence would make it impossible to do the job, the view that discussion was pointless as the reason for the incident was known, and reluctance because of violence in one's own past. There was some acknowledgement that the nurse in charge set the tone for the frequency and content of discussions and that all staff had a duty to participate. The study also showed that perceptions of the involvement of managers in post-incident discussions varied from regular involvement to no involvement at all.

Willingness to discuss the formulation of care plans varied by setting: staff inertia was identified as a factor that inhibited such discussion. As well as within-shift discussions, this study also raised the importance, as perceived by interviewees, of cross-shift discussions to formulate consistent policies towards patients and to identify reasons why the frequency of incidents and the methods of management differed between shifts on the same ward. In summary, this study revealed a wide range of factors that might affect the willingness of staff to engage in discussion about violence.

iii) Subsequent developments

The importance of discussion has continued to be emphasised, all recent guidelines reiterating its importance. Benson and Balfe (2001). however, have recently argued that post-incident discussions should fulfil three different functions: expressing immediate feelings; understanding why the incident occurred and how it might best be presented in future; and investigating individual accountability. They suggest that it might be better for each function to be dealt with separately and managed by different personnel (Benson and Balfe 2001).

There is, however, much discussion at present about the culture of blame in healthcare. When things go wrong, the emphasis is on finding an individual or individuals to blame rather than looking for faults within the system as a whole (RCP 1997, Vincent *et al.* 2000). Guidelines emphasise that when discussing violent incidents, the climate should be one in which the emphasis is not on blaming individuals but rather on identifying ways of preventing violence and better managing that which occurs (Section 2.10.2 ii)). It has been argued, however, that there may be a conflict between this agenda of open discussion and the policy of *Zero Tolerance* of violence, since the latter may militate against an understanding of why violence occurs (Benson *et al.* 2003).

11.3.4 Category 4: Feeling valued

This category had three properties: other professionals valuing nurses' views about violence; other professionals fulfilling their responsibilities; and provision of resources that facilitated nurses in the prevention and management of violence. Each property was concerned with actions of others identified as increasing the likelihood of violence or undermining nurses' approaches to its prevention and management.

i) Prior to study

Prior to this study, guidelines on violence had recommended that medical staff and nurse managers should respect the views of nurses; for example in taking their views into account over the admission of patients and abiding by decisions made in post-incident discussions about reasonableness of staff conduct (Section 2.2.2 ii)). Research in the UK had provided examples of situations in which nursing and medical staff differed in their views on whether medical staff did take nurses' views into account in this respect (Section 3.3.3).

There had been a long-standing view that mental health services were under-resourced and that this reflected a low priority accorded to the needs of people with mental illness (Brooking 1985). The guidelines of the 1970s had stressed the importance of adequate staffing and sufficient activities to minimise the boredom regarded as conducive to violence and these factors were considered in some of the studies undertaken prior to my study (Sections 3.3 and 3.5).

ii) Findings from this study

This study revealed a wide range of matters, relating to violence and affecting nurses' working lives, on which interviewees felt their views should be taken into account by medical staff and/or by nurse management. The extent to which their views were taken into account, however, varied considerably. They had little input into decisions about the context of care delivery (ward design and changes to admission procedures) and decisions about relocating groups of patients within the site. They had little input into decision-making about the admission of patients but there were signs that this was beginning to change with preliminary moves towards multidisciplinary working. The influence of nurses was seen, in some instances, as being dependent on their assertiveness as individuals. Input into decision-making about treatment of patients revealed a very mixed picture in that staff within the same setting often had differing views on whether medical staff did and should take nurses' views into account. Views about valuing nurses' interpretations of incidents, however, were much less divergent in that most of those in institutional settings felt that their views were discounted by nurse managers, medical and tutorial staff. Staff working in the community settings were less likely to express this view.

Nurses held that they had little input in certain decisions that affected the nature of care despite being the personnel in most contact with patients. Valuing each others' views about aspects of patient care did, however, lie within their power and showed a mixed picture; some junior staff felt that their views were acted upon, others that they were ignored.

The study also showed how nurses were 'left to bear the brunt' of violence as a result of other professionals failing to fulfil their roles. In the main, this focused on provision of

information by medical staff to patients and to staff. Nurses perceived lack of a wide range of resources as impacting on violence including staffing levels, equipment and materials for recreational activities, therapeutic sessions. space. food and security systems. Community staff perceived that they were less valued than other health professionals since the latter were provided with sufficient staff to visit in pairs and had alarms in their office, whereas community staff were not.

iii) Subsequent developments

Since this research was undertaken there have been developments that should have increased the extent to which nurses' views are taken into account in relation to violence. There has been increased multi-professional working (e.g. Stark *et al*. 2000) and initiatives to involve staff in service design and change (DH 1997b). Moreover, there is growing recognition that violence must be seen as a problem for organisations rather than individuals (Section 2.10.2 ii)).

11.3.5 Category 5: Being supported by actions of others

This category was concerned with nurses being supported by the actions of others over potential and actual violence and its aftermath.

i) Prior to study

Prior to this study, reference to support for nurses in published policy documents had focused on staff having the right to expect the support of the hospital authority over actions they had taken in good faith in relation to violence (Section 2.2.2 ii)). Research on support in the aftermath of incidents (e.g. Conn and Lion 1983) had shown that views varied on whether it had been available (Section 3.8).

ii) Findings from this study

Support from others was identified as important in relation to many aspects of preventing violence and managing incidents, and in relation to post-incident events. A five-point continuum emerged from the analysis: being willing and able to support; being willing but unable to support; not being willing but nonetheless providing some support; not being willing and not providing support; and not recognising that support was needed. Nurses' views suggested that lack of support was not always due to lack of

willingness but also identified constraints that undermined willingness such as fear of outcome and not being supported oneself.

Providing support to colleagues in the setting did lie within nurses' power and in the main, support was perceived as being available. Some men, however, felt that women should, but did not, support them in the management of violence, whereas women interviewees maintained that they were supportive. Nurse managers were viewed in a somewhat negative light, particularly over providing support for nurses who had been involved in incidents, although it was suggested that this might be due, in turn, to their feeling unsupported by managers senior to themselves.

iii) Subsequent developments

Since this study there has been increasing emphasis on support for staff both in relation to their emotional needs and in dealing with legal matters that might ensue (Section 2.10.2 ii)), primarily in the aftermath of incidents. Research has focused on perceptions of male and female staff of their respective roles in the management of violence (Section 3.13) and on the need for, and the effects of, provision of support concerning recovery from the trauma of the incident (Section 3.14).

11.3.6 Category 6: Judging responses

This category comprised actions constructed in light of interviewees' perceptions of how others would perceive and respond to them. The category related both to relationships between nurses and patients and to relationships between nurses and other health professionals.

The study revealed that interviewees regarded violence by mentally ill patients as an acceptable part of the job. Findings also showed that nurses made a distinction between patients whose violence they attributed to mental illness and those whose violence they perceived as antisocial behaviour; they felt angry with the latter but not the former and felt particularly aggrieved about violence from patients whom they regarded as having a personality disorder. The study also showed how nurses constructed different responses to these two groups of patients. Subsequent research has explored in considerable detail the ways in which nurses perceive violence by different groups of patients (Section 3.15).

This study revealed a wide range of situations in which nurses constructed their actions in light of how other professionals would perceive them. The motivation underpinning some of these actions was one of not wanting to incur censure; current discussion about mental health practice suggests that a climate still exists that increases the likelihood of staff acting in this way. Findings also showed that on occasion, staff did not want to admit feeling upset or stressed in front of colleagues or managers, since a culture existed that would interpret this behaviour as a sign of weakness. Subsequent work suggests that staff may still feel so (e.g. Wykes and Mezey 1994).

11.3.7 Category 7: 'No win' situations

This category illuminated a type of situation in psychiatric settings that have been colloquially referred to elsewhere as 'no win', where whatever action was undertaken, an adverse outcome was likely. The analysis revealed four kinds of such situations, all focused on patients' rights and/or staff safety: choosing between patients' rights or staff safety; risking an aggressive response from patients whichever course of action was adopted; taking the risk of incurring blame for the outcome whatever choice was made; and having to make a choice between one's own safety and that of colleagues. The study thus revealed complexities and difficulties of circumstances in which nurses may find themselves, in having to make decisions about fulfilling the demands of both patients' rights and staff safety knowing that either choice may have an adverse outcome.

Achieving a balance between patients' rights and staff safety remains as much a concern today as it was when this study was undertaken (Sainsbury Centre for Mental Health 2000). A 'no win' perspective may be useful to adopt in reviewing and analysing practice in relation to violence and may lead to recognition that nurses may have acted to the best of their ability even when there has been an adverse outcome for patients and/or staff. Moreover, it may lead to identification of means to resolve situations in ways that ameliorate at least one of the adverse outcomes.

11.3.8 Implementing strategies

The last category to be developed provided a link across the others. The study showed that nurses identified a range of strategies to prevent and manage violence that lay

within their power. whether or not they actually implemented those strategies. The study also showed that nurses identified a range of strategies that impacted on the incidence, prevention and management of violence but which lay outside their power to implement. The power lay. rather. with medical staff, tutorial staff. nurse and service managers, and those with responsibilities at organisational levels beyond the local service context.

There had long been recognition that actions of other professionals can affect the work of nurses in relation to the management of violence; this was manifest in the guidelines of the 1970s (Section 2.2.2 ii)). An organisational perspective emerged in guidelines and policy documents from the mid 1980s onwards. with identification of the responsibilities of those at each level for implementing strategies (Section 2.10.2 ii)). The contribution of this category was to reveal ways in which nurses` perceived that a wide range of factors, many originating outside their immediate work setting, could nonetheless have a bearing on the incidence, prevention and management of the violence they encountered and over which they perceived themselves as having little influence.

11.4 GENERALISABILITY OF THE FINDINGS

This study was a small-scale qualitative project, fieldwork for which was undertaken in one health district in the late 1980s. Section 4.2.2 provided a discussion of positions at the time about generalising from a case study of this kind. The first position was that of `naturalistic generalisation` in which a case study illuminated critical or significant elements of the situation and others could use the insights generated when considering their own situation (Stake 1978). The second position placed greater emphasis on the cogency of theoretical reasoning as the basis for inference to other situations (Silverman (1985). Recent writing on the subject of generalisation from case studies demonstrates how these debates are still current (e.g. Hammersley *et al.* 2000, Schofield 2000). The position I have adopted with this study is described below.

The question arises of whether the settings to which interviewees' views and experiences related are similar to the settings that comprise current mental health services (Section 2.7). The services provided by the acute care locked ward (Chapter 6)

are now to be found in acute in-patient units that are sited in general hospitals or exist as small free-standing units. Rehabilitation services (Chapter 8) are sited in the community rather than on hospital sites and take the form of residential units, day hospitals and rehabilitation services provided in the home. Community psychiatric nursing services (Chapter 9) have expanded considerably and staff are now much more likely to be working as members of multidisciplinary teams, for example community mental health teams, home treatment teams and assertive outreach teams. The continuing care, medium- and long-stay wards are the settings that have changed most with the closure of the large psychiatric hospitals. The policy is now for patients requiring continuing care to be placed in units providing 24-hour-nursed beds, while patients who were on long-stay wards have mainly been discharged to community facilities such as group homes. In summary, the same range of patient groups exist but locations of services have changed in the ways described.

The schema of categories that I developed represented a modest attempt at moving beyond a descriptive account of the settings and provides a framework that integrated a wealth of findings across six settings. In Section 11.6, I suggest that the best way to assess the current relevance of the framework would be to use it to explore the views and experiences in relation to violence of nurses working in today's mental health services.

11.5 IMPLICATIONS FOR POLICY

This study was undertaken at a time of concern about violence in psychiatric services and sought to explore the views and experiences of nursing staff on the subject. The rationale for the study was that the perspectives of those working in the services should be an important component in the development of strategies to reduce violence and better manage that which occurs. The study revealed how interviewees perceived a wide range of factors as impacting on the generation of incidents in the settings in which they worked and on their capacity to prevent and manage these. The study also revealed ways in which interviewees perceived that certain strategies to prevent and manage violence lay within their power to implement whereas the power to implement others lay elsewhere. The study lends itself neither in its design nor in its distance from today's mental health services, to specific policy recommendations. Rather, it identifies

the broad range of areas in which policy-making is relevant to violence in the settings in which nurses work. These areas of policy are outlined in relation to the seven substantive categories developed in this study and to some extent in relation to the organisational framework identified by Vincent *et al.* 2000 (Section 10.3).

11.5.1 Providing appropriate services (Appropriate placement)

In relation to violence in patient care settings, the ideal position from the perspective of nurses is that each patient is placed in a setting that has the level of security and resources appropriate for their care. Current policies advocated by central government for the mental health services are designed to ensure that appropriate placement can be achieved (Section 2.9) and evaluation will be needed of the extent to which this is successful. At health authority level, polices for appropriate placement are concerned with ensuring that resources for the provision of mental health services are allocated for the purpose intended.

11.5.2 Providing resources (Feeling valued)

Various kinds of resources are regarded as relevant to the generation and prevention of violence in patient care settings: buildings; availability of therapeutic programmes, equipment and materials for recreational and other aspects of daily life; staffing; and security systems. At a national level provision of resources for mental health services depends on the priority accorded this group of patients and at health authority and trust levels on the way such resources are allocated in the face of other competing demands.

Adequate staffing levels of other health professionals as well as nurses has long been a problem in the mental health services and recent reports reveal the magnitude of the problem (Sainsbury Centre for Mental Health 2000). Improving staffing levels is a complex matter of improving career progress and development and quality of working life, all of which are foci of much of the current human resources agenda. Initiatives by local Workforce Development Confederations to develop a local workforce through widening access into education and into healthcare professions, as an alternative to relying on agency and overseas staff, may prove to be important for mental health services. For staff who encounter violence in the settings in which they work, the perception that inadequate resources increases the incidence of violence and reduces

their capacity to prevent and manage incidents, may further exacerbate attrition from the workforce.

11.5.3 Education and guidance (Knowing what to do)

At national level, policies concerned with education and guidance relate to the pre-registration curriculum, nationally coordinated programmes of accredited courses for staff, adequate resourcing of continuing professional development, and development of guidelines. The education of nurses in relation to violence raises a range of issues for trusts, higher education institutions and workforce development confederations. These include adequately supported placements to ensure that students obtain relevant experience, a focus on the development of mental health nursing skills in the context of the four-branch diploma programme, and collaboration between service and education staff over the content of teaching. Achieving a balance between ensuring adequate preparation while not emphasising the subject to the point that students are deterred from wanting to practise may present a challenge. At trust level, the implementation of programmes of continuing professional development requires staffing levels that enable individuals to be released to attend courses and funds for the cost of courses. At the level of the workplace, continuing professional development in the form of staff reflecting on practice, the provision of clinical supervision for qualified staff and the mentoring of students all have implications for staff time and training. Developing guidelines that staff perceive as relevant and accessible is another area of policy to be considered.

11.5.4 Organisational climate (Being supported, willingness to discuss, judging responses, 'no win' situations)

Policy development concerned with nurses' experience of violence also relates to what is often referred to as the 'organisational climate' in which nurses work. Aspects of this climate discussed by interviewees in my study included: the clarity of their legal position in matters relating to violence; support from senior management when involved in incidents; the question of pursuing charges against patients who assault them; the extent to which their views were acknowledged and acted upon; a willingness or otherwise to discuss violence; and facing situations in which an adverse outcome appeared likely whatever action they took. Each of these issues is the subject of

ongoing debate and likely to involve initiatives by national organisations as well as by the organisations in which nurses work.

11.6 DIRECTIONS FOR FURTHER RESEARCH

This study of nurses' views and experiences in relation to violence in six settings revealed their perceptions about the ways in which a diversity of factors contributed to the generation of violence and on their capacity to prevent and manage incidents. In considering its implications for further research, I suggest an exploration of the views and experiences of nurses, working in a range of settings, using the schema of categories developed in this study. This would indicate whether the categories developed resonated with the views and experience of nurses working in today's mental health services. If such a resonance was indicated, then consideration could be given to further developing and evaluating the schema.

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APPENDICES

APPENDIX 1
APPROACH TO REVIEWING RESEARCH LITERATURE ON VIOLENCE

Section 3.10 discusses the approach taken to reviewing the substantial body of research on violence that has occurred since the fieldwork for this thesis was completed. The purpose of this appendix is to provide a fuller account of this approach.

Prior to the time when I undertook the fieldwork for this study (1986-87) there had been very little research that encompassed nurses' views and experiences in relation to violence. The available policy (Chapter 2) and research (Chapter 3) literature was reviewed to identify dimensions of violence and to formulate a conceptual framework to guide data collection (Figure 4.1). Since so little was known on the subject, the conceptual framework and the interview guides that were developed (Appendices 2 to 6) included a wide range of topics. While concern about the subject centred mainly on acute services, the review also indicated concern in others. Consequently, it was decided to include all the main services for adult patients in this study.

Since completion of fieldwork I have kept up to date with subsequent literature on violence and mental health nursing in two ways. First, I have continued to read those journals in which research papers about violence and mental health nursing are most likely to be published. These include: the Journal of Mental Health; Journal of Psychiatric and Mental Health Nursing; the International Journal of Mental Health Nursing; Mental Health and Learning Disabilities Care; Medicine, Science and the Law; the Journal of Advanced Nursing, the International Journal of Nursing Studies; and Nurse Education Today. Secondly, I undertook two electronic searches, one in late 2000 and another in late 2003, using CINAHL, PsycINFO, Medline and EMBASE. Together, these approaches revealed a very substantial volume of papers relating to research undertaken in the United Kingdom and a range of other countries.

As far as I could ascertain, no other study had taken a similar approach to mine in studying a wide range of dimensions of violence in all the main services for adult patients and then developing substantive categories from their detailed findings (see Section 5.8). Rather, subsequent work had focused in varying degrees of depth and breadth on one or more dimensions of violence, usually in one service rather than

several. Reviewing subsequent research was not, therefore. a case of demonstrating how this work had developed and expanded my own. Nonetheless. an important part of the thesis was to demonstrate the nature of this subsequent work and how my own study was positioned within it.

To include such a review in its entirety in this thesis presented a problem since it would have required far more space than was available. Moreover, other substantial reviews exist, most notably that undertaken by Wright and colleagues (Wright *et al.* 2002). I decided that the most appropriate approach to adopt to this literature in the context of this thesis was to demonstrate the main directions that had been pursued that had relevance to nurses' experiences and views about violence. Having made this decision, I then concluded that it would be more informative for readers if, for each direction, I cited just a few studies with details of the methods adopted and main findings to emerge rather than covering more studies with less information about each. The danger of the latter approach was that it would become a list of references rather than a demonstration of the diversity of topics investigated and the methods adopted.

APPENDIX 2
INTERVIEW GUIDE FOR STAFF IN INSTITUTIONAL SETTINGS

1. Introducing the study

Describe study, reason for including interviewee, permission to record, guarantees of confidentiality and anonymity

2. Professional background

When qualified as a psychiatric nurse
Nursing qualifications gained
Psychiatric nursing
Length of time worked in this setting

3. Details of setting

Number of patients and range of conditions
Routes whereby patients are admitted to setting, length of stay
Number of consultants with patients in setting

Locked ward only:
(Proportion of patients from community, from other wards, other routes)

Aims of the programme of care provided

Number and grade of staff usually on shift
Views about adequacy of staffing re programme, re violence
Employment of agency staff
Views about agency staff working in setting

4. Definitions

Encourage to provide definitions of aggression and violence

5. Manifestation and incidence

Explore kinds of incidents that occur in setting, include violence from relatives, and self-harm
Encourage to describe specific incidents
Views about frequency
Own involvement in incidents

NB In subsequent sections refer back to specific incidents described

6. Explaining violence

Views on what leads to incidents in setting

Probe on:

Mental illness, conditions in setting, programme of treatment/care, frustration with circumstances

Actions of medical staff, other professionals, other patients

Whether staff approach/attitude to patients may be a factor

Relevance of gender and ethnic group to incidents

Locked ward only:

(Effect of being in a locked ward on incidents)

Explore whether any other factors not mentioned as yet

7. Preventing violence

In relation to views given about explanation, explore views on prevention

Explore views on whether specific incidents described might have been prevented

Any changes that would like to see that think might lead to reduction in incidents

8. Information

Views on adequacy of communication about patients with a history of violence between:

Nursing staff on this shift

Nursing staff on other shifts

Nursing and medical staff

9. Guidelines

Existence in the setting of guidelines about violence

Knowledge of content

Views about usefulness

10. Managing violence

Approach to 'first signs' of violence

Action when incident starts: explore coordination of action

Methods of managing incidents, explore specific incidents that have been described, include what happens to patient after incident

Problems perceived in managing incidents

Locked ward only:

(Use of seclusion)

Any changes that would like to see in management of incidents

11. Routes to admission to setting
Views on whether all patients in setting are in best place in relation to their needs and available resources
If not, does this relate to violence in any way
Ease of moving patients elsewhere
Involvement of nursing staff in decisions about admission of patients

Locked ward only:
(Involvement of nursing staff in decisions about transferring patients to locked ward
Views about appropriateness of transfer
Ease of transfer back to own ward

Involvement of nursing staff in decisions about admitting patients on a Section 136
Appropriateness of admission of these patients
Nature of relationships with police

Views on whether some patients on locked ward need greater security
Ease of transfer to more secure settings)

12. Role of locked ward
Views on whether locked ward needed
Effect on managing violence in open settings

13. Post-incident events
Procedures for, and views about, recording incidents
Existence of post-incident discussions
Involvement of line manager in discussions
Benefits of discussions
Reasons for not having discussions
Discussions with patients

14. Differing views about violence
Explore knowledge of views of other nursing staff about violence
Effect of differing views

Views of nurse managers about violence and whether differ from those of staff
Extent to which nurse managers take account of nursing staff's views about incidents
Effect of differing views

Views of medical staff about violence and whether differ from those of staff
Extent to which medical staff take account of nursing staff's views about violence
Effect of differing views

Teaching settings only:
(Knowledge of views of teaching staff about violence and whether differ from those of setting staff)

15. Support
Support available over violence (prevention, management and post-incident) from:
Nursing staff in setting
Line manager and senior nurse management
Medical staff

16. Involvement in policy-making
Involvement of nursing staff in policy-making perceived as relevant to preventing and managing violence
Views about current extent of involvement

17. Feelings about violence
Feeling afraid/scared
Feelings towards patients when self/colleagues assaulted; explore whether feelings differ by perceptions of patient's condition
Views on staff safety

Locked ward only:
(Feelings over whether ward is a stressful place to work
Whether chose to work here or allocated
Comparative risk to safety compared with other settings)

18. Legal position
Whether hold views about legal position of nurses in relation to violence
Probe on:
Informally detained patients and nurses' actions
Position of nurses involved in restraint
Effect of views on practice

Appreciate that may be a difficult balance but interested in:
Views about the balance between patients' rights/safety and staff's rights/safety

19. Own skills and training
Views on skills you need in preventing and managing violence in this setting
Adequacy of own training re violence
Information about any training after qualification
Views on whether post-basic training is needed
Training in procedures for physical restraint

Nature of experience of violence in other settings

Views about learning about preventing and managing violence
Probe on balance between teaching and experience

20. Teaching learners about violence

For settings to which learners allocated
Own involvement in teaching
Learning experiences for students in relation to violence
Nature of contact between tutorial and setting staff
Knowledge of what students taught in school about violence
Views about students having a placement on the locked ward

Locked ward only:
(Knowledge of why ward not currently included in teaching circuit
Views as to whether it should be included and reasons for views
If yes, at what stage should learners have a placement)

21. Serious incidents

I'm aware that there have been some very serious incidents at this hospital
Explore whether wish to discuss these
If yes, views on what happened and how they felt about events

22. Any other topics

Explore if interviewee feels that has had opportunity to discuss everything that felt relevant to subject

23. Personal details

Age last birthday
Future plans

APPENDIX 3
INTERVIEW GUIDE FOR STAFF IN COMMUNITY SETTINGS

1. Introducing the study
Describe study, reason for including interviewee, permission to record, guarantees of confidentiality and anonymity

2. Professional background
When qualified as a psychiatric nurse
Nursing qualifications gained
Psychiatric nursing experience
Length of time worked in community

3. Details of working arrangements
For generic service and specialist services:
CPNs' working arrangements
Routes whereby patients referred to CPN service
Working relationships with medical staff re referral of patients
Aims of service provided by CPN

Caseload and views on adequacy of staffing
Views about visiting in pairs

4. Definitions
Encourage to provide definitions of aggression and violence

5. Manifestation and incidence
Explore locations in which incidents occur, including journey to patients' homes
Explore kinds of incidents that occur including violence from relatives
Encourage to describe specific incidents
Views about frequency
Own involvement in incidents

NB In subsequent sections refer back to specific incidents described

6. Explaining violence
Views on what leads to incidents in setting
Probe on:
Mental illness, frustration with circumstances, programme of treatment/care
Actions of medical staff, other professionals
Probe on:
Views as to whether staff approach/attitude to patients may be a factor
Views on relevance of gender and ethnic group to incidents

Explore whether any other factors not mentioned as yet

7. Preventing violence
In relation to views about explanation, explore views on prevention
Explore views on whether specific incidents described might have been prevented
Views about how to increase safety when making journeys to patients` homes

Any changes that would like to see that think might lead to reduction in incidents

8. Information
Views on adequacy of communication about patients with a history of violence between:
CPNs
CPNs and other staff

9. Guidelines
Existence of guidelines about violence in community settings
Knowledge of content
Views about usefulness

10. Managing violence
Approach to 'first signs' of violence
Actions when unable to calm patient down
Own actions
Involving others

11. Routes to referral
Views about appropriateness of referrals to service
Transfer of patients to institutional settings and/or to care of other professionals
Ease of transfer to more secure settings

12. Post-incident events
Means by which incidents could be discussed with other CPNs. other professionals
Involvement of line manager in discussions
Benefits of discussions
Reasons for not having discussions
Discussions with patients

13. Differing views about violence
Opportunities for discussing violence
Explore knowledge of views of other nursing staff, other professionals about violence
Effect of differing views

14. Support
Support available over violence (prevention, management and post-incident) from:
Other CPNs
Line manager and senior nurse management
Medical staff

15. Involvement in policy-making
Involvement of nursing staff in policy-making perceived as relevant to preventing and managing violence
Views about current extent of involvement

16. Feelings about violence
Views on staff safety
Feeling afraid/scared
Feelings towards patients when self/colleagues assaulted

17. Legal position
Whether hold views about legal position of nurses in relation to violence

Appreciate that may be a difficult balance but interested in:
Views about the balance between patients' rights/safety and staff's rights/safety

18. Own skills and training
Views on skills you need in preventing and managing violence in community settings
Adequacy of own training re violence
Information about any training after qualification
Views on whether post-basic training is needed
Training in procedures for physical restraint

Nature of experience of violence in other settings

Views about learning about preventing and managing violence
Probe on balance between teaching and experience

19. Teaching learners about violence
Own involvement in teaching
Learning experiences for students in relation to violence

20. Serious incidents
I'm aware that there have been some very serious incidents at the hospital
Explore whether wish to discuss these
If yes, views on what happened and how they felt about events

21. Any other topics

Explore if interviewee feels that has had opportunity to discuss everything that felt relevant to subject

22. Personal details

Age last birthday

Future plans

APPENDIX 4
INTERVIEW GUIDE FOR NURSING AUXILIARIES

1. Introducing the study
Describe study, reasons for including interviewee, permission to record, guarantees of confidentiality and anonymity

2. Background
Length of time as a nursing auxiliary
Length of time in this setting

3. Setting and role
Number of patients in setting and knowledge of their conditions
Nature of work as a nursing auxiliary in this setting
Training for work of nursing auxiliary
Staffing levels and views of adequacy

4. Violence in setting
Explore kinds of incidents that occur in setting
Views about frequency of incidents
Own involvement in incidents

5. Explaining violence
Views as to why incidents occur:
Probe on:
Mental illness, conditions in setting, actions of others
Staff approach/attitude to patients, gender and ethnic group

Explore whether any other factors not mentioned as yet

6. Preventing violence
Explore views on NAs' roles in preventing incidents
Views on how might be better prevented

7. Managing violence
Explore role as NA when patients become aggressive
Explore what happens when patients can't be calmed down: sending for help, involvement in restraint

8. Post-incident events
Explore involvement of NAs in post-incident events: recording of incidents, involvement in discussions after incidents or at handover, views about wanting discussion

9. Feelings about violence
Explore whether sometimes feel afraid/scared
Explore attitudes towards encountering violence during course of work

10. Training in preventing and managing violence
Means of learning about preventing and managing violence
Any specific training in restraint
Any knowledge of guidelines
Views on whether training wanted

11. Relationships with other staff
Explore working relationships with qualified staff
Any involvement with medical staff or nurse managers

12. Any other topics
Explore if interviewee feels that has had opportunity to discuss everything that felt was relevant to subject

13. Personal details
Age last birthday
Plans

APPENDIX 5
INTERVIEW GUIDE FOR NURSE MANAGERS (SEVERAL SERVICES)

1. Introducing the study
Describe study, reason for including interviewee, permission to record, guarantees of confidentiality and anonymity

2. Professional background
When qualified as a psychiatric nurse
Nursing qualifications gained
Psychiatric nursing experience
Length of time in current post

3. Violence overview
Incidence in different services
Whether patients in best setting in relation to their needs and available resources

4. Explaining violence
Views on what leads to incidents in the various settings
Probe on:
Mental illness, programme of treatment/care, conditions in setting, staff approaches/ attitudes to patients, action of other professionals/patients

5. Preventing and managing violence
Skills needed by nurses in preventing and managing violence

6. Guidelines
Existence and perceptions of usefulness

7. Locked ward
Views on need for locked ward
Effect on managing violence in open settings

8. Post-incident events
Knowledge of existence of post-incident discussions
Reasons for discussions not being held
Benefits of discussions

9. Legal position
Legal position of nurses in relation to violence
Balance between patients' rights/safety and staff's rights/safety

10. Education
Adequacy of basic and post-basic education for nurses in relation to violence
Balance between education and experience
Views about locked ward placements
Relationships between service and education staff

11. Any other topics
Explore if interviewee feels that has had opportunity to discuss everything that felt was relevant to the subject

12. Personal details
Age last birthday
Plans

APPENDIX 6
INTERVIEW GUIDE FOR NURSE MANAGERS (ONE SERVICE)

1. Introducing the study
Describe study, reason for including interviewee, permission to record, guarantees of confidentiality and anonymity

2. Professional background
When qualified as a psychiatric nurse
Nursing qualifications gained
Psychiatric nursing experience
Length of time in current post

3. Details of setting
Number of patients and range of conditions
Number of consultants with patients in setting
Nurse staffing
Routes whereby patients are admitted to setting and views about whether in best place in relation to their needs and available resources
Own role in setting

4. Definitions
Encourage to provide definitions of aggression and violence

5. Manifestation and incidence
Explore kinds of incidents that occur in setting
Views about frequency

6. Explaining violence
Causes of incidents in setting
Probe on:
Mental illness, programme of treatment/care, conditions in setting, staff approaches/ attitudes to patients, action of other professionals/patients

Explore whether any other factors not mentioned as yet

7. Preventing and managing violence
Skills needed by nurses in preventing and managing violence
Knowledge of management of incidents in setting

8. Guidelines
Existence and perceptions of usefulness

9. Locked ward
Views on need for locked ward
Effect on managing violence in open settings

10. Post-incident events
Knowledge of existence of post-incident discussions
Reasons for discussions not being held
Benefits of discussions
Providing support for staff involved

11. Legal position
Legal position of nurses in relation to violence
Balance between patients' rights/safety and staff's rights/safety

12. Education
Adequacy of basic and post-basic education for nurses in relation to violence
Balance between education and experience
Views about locked ward placements
Relationships between service and education staff

13. Any other topics
Explore if interviewee feels that has had opportunity to discuss everything that felt relevant to subject

14. Personal details
Age last birthday
Plans